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**Understanding Compassion:
A Constructivist Grounded Theory
Study to Explore the Perceptions of
Individuals Who Have Experienced
Nursing Care**

C. Straughair

PhD

2016

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**Understanding Compassion:
A Constructivist Grounded Theory
Study to Explore the Perceptions of
Individuals Who Have Experienced
Nursing Care**

Collette Straughair

A thesis submitted in partial fulfilment of
the requirements of the University of
Northumbria at Newcastle for the degree
of Doctor of Philosophy

Research undertaken in the Faculty of
Health and Life Sciences, Northumbria
University

October 2016

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Abstract

Background

It has been suggested that compassion is aspirational, rather than a reflection of the reality of contemporary nursing practice. This notion is reflected through reported negative experiences of nursing care, encountered by individuals across a range of age groups and care contexts. In response, a political and professional reaffirmation has ensued to declare that compassion remains a core philosophy of nursing, although this provides limited articulation of what compassion entails. Furthermore, there is limited empirical research to explore compassion exclusively through the perceptions of individuals who have experienced nursing care, highlighting a gap in existing knowledge.

Aim

The aim of the research was to address this gap in knowledge and develop a more comprehensive understanding of compassion in nursing. Specifically, the research aimed to explore compassion, exclusively, through the perceptions of individuals who had personal experience of nursing care.

Methodology and Methods

A constructivist grounded theory methodology was implemented, influenced by the theoretical perspectives of symbolic interactionism and social constructionism. The target sample population comprised a group of individuals who were in an established role to contribute to teaching and learning strategies to undergraduate health students within the university setting. Applying a theoretical sampling strategy, data was collected via eleven individual interviews, a focus group discussion with three participants and three additional individual interviews. Data was analysed using initial, focused and advanced coding techniques, supported by constant comparative analysis.

Findings

Five data categories were generated from analysis. This comprised the four major categories of *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and the core category of *Humanising for Compassion*. Advancing reflexivity to consider these data categories at a more conceptual level identified that compassion was fundamentally

characterised by experiences of humanising approaches to nursing care, which were dependent upon the equilibrium of five interrelated elements of compassion. These elements comprised *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. The five elements of compassion were subject to further influence by three overarching principal dimensions of compassion, which comprised *Compassionate Self*, *Compassionate Interactions with Others* and *Compassionate Situational Contexts*. In order to reflect participant perceptions of the complex nature of compassion, a grounded theory was constructed and assimilated into *The Model of Compassion for Humanising Nursing Care*. The new theoretical insight gained from this model provides a more comprehensive understanding of what compassion in nursing involves, offering an original contribution to the existing knowledge base and a foundation from which to address emerging implications for practice and opportunities for future research.

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To all the other people who have listened, offered support, advice and guidance throughout this journey, thank you to you all.

Dedicated to my Dad

I hope you would have been proud

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Ethical clearance for the research presented in this thesis has been approved.

Approval was sought and granted by the Faculty Ethics Committee on 12/2/12.

I declare that the word count is: 83, 936 across Chapters 1-7 of the thesis

Name: Collette Straughair

Signature:

Date: 10/10/2016

*“Love and compassion are
necessities, not luxuries.
Without them, humanity
cannot survive”*

Dalai Lama XIV

Chapter 1: Introduction to the Research

1.1 Chapter Introduction

Compassion is the most precious asset of nursing (Schantz, 2007), originating in the United Kingdom from theological traditions of caring for the sick (Shelly and Miller, 2006; Armstrong, 2007; Kapelli, 2008 a, b) and attributed to professional nursing through the influences of Florence Nightingale (Bingham, 1979; Dolan, Fitzpatrick and Herrman, 1983; Dingwall, Rafferty and Webster, 1988; Widerquist 1992). Since the professionalisation of nursing in the late 19th century, compassion has been regarded as synonymous with the underpinning philosophy of nursing practice (Rafferty, 2011). However, over recent years the notion of compassion has been questioned, as a result of an emerging wealth of individuals who have reported negative experiences of compassion in the nursing context (Mooney, 2009).

Despite a political and professional reaffirmation that compassion continues to be a core philosophy of contemporary nursing, there is limited empirical research to elucidate what compassion involves, particularly from the perceptions of individuals who have experienced nursing care. Olshansky (2007) suggests that until a more comprehensive understanding is achieved, nurses will be unable to claim compassion as an integral dimension of practice. This thesis addresses this gap in knowledge, through the doctoral research that was undertaken during the period October 2011 to October 2016 to explore compassion from the perceptions of individuals who have experienced nursing care.

This introductory chapter establishes the primary impetus for engaging in the research, presenting a personal rationale to support this and briefly situating compassion in nursing. The primary question and objectives underpinning the research are outlined and an overview of the research approach and design provided. Where appropriate, definitions are specified to clarify key terms used throughout the thesis. The chapter concludes with an overview of the organisation of the thesis, providing a brief summary of the content of each chapter to delineate the work.

1.2 Establishing the Primary Impetus for Research

Prior to commencing my doctoral journey, I was an Admissions Tutor in a Higher Education Institute in the North East of England which provides undergraduate nurse education to approximately four hundred adult nursing students annually. The recruitment and selection of candidates to enter this programme was an integral part of my role. As an academic involved in the interview and selection process, I began to reflect upon the reasons why certain candidates were considered appropriate for a career in nursing, and subsequently chosen to embark upon the programme over others.

A personal awareness of my experiential and intuitive perceptions about the particular qualities and attributes required by candidates pursuing a career in nursing was evident. These perceptions had evolved as a result of extensive professional experience as a Registered Nurse and Registered Midwife, personal experiences of care and observations of care delivered to family members. However, I was keen to enhance this knowledge from an academic perspective and this led to engaging in

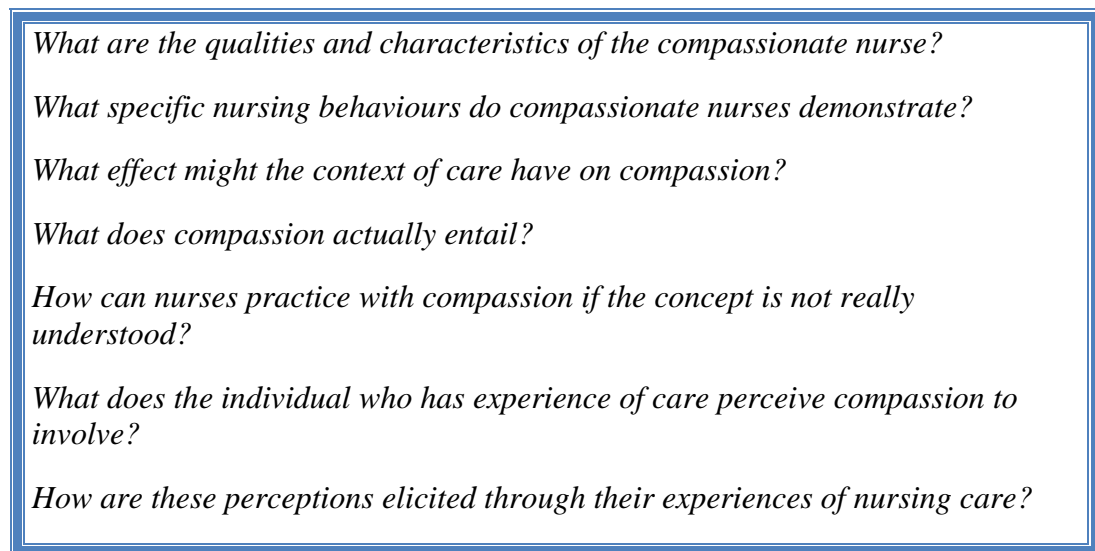
discussions with academic colleagues, professional peers and an initial exploration of extant literature. This process identified a fervent interest in compassion, a concept I personally perceived to be an essential and integral philosophy of nursing, but one which I had only limited understanding of in scholarly terms. Engaging with extant literature to contextualise compassion in nursing led me to develop an article, 'Exploring Compassion: Implications for Contemporary Nursing Practice. Part 1 and 2' (Straughair, 2012 a b). The article was submitted for publication in the months preceding my application for doctoral study, and published in the British Journal of Nursing in January 2012 (Appendix 1).

At the time of my emerging interest in compassion as a research focus, an increasing awareness of negative experiences of nursing care was also transpiring. This was evident from a range of literature, which highlighted a lack of compassion to be a significant factor contributing to the negative experiences reported by a variety of individuals, across a range of age groups and diverse contexts of care (Youngson, 2008; The Patients Association, 2009; The Mid Staffordshire National Health Service (NHS) Foundation Trust Inquiry, 2010 a, b; BBC, 2011; Care Quality Commission (CQC), 2011 a, b; The Parliamentary and Health Services Ombudsman, 2011; The Patients Association, 2011; CQC, 2013; The Mid Staffordshire National Health Service (NHS) Foundation Trust Inquiry, 2013; Chubb, 2013 a, b, c; BBC, 2014; Granger, 2015). These reported negative experiences were instrumental in highlighting the need for the nursing profession to reconsider the concept of compassion. This ensued in a phase of uncertainty, where the notion of compassion as an integral and traditional philosophy of nursing care was questioned (Mooney,

2009). As a result, a reactionary response from a variety of political and professional arenas emerged, providing policy and guidance to reaffirm that compassion continued to be a core, underpinning philosophy of nursing (Department of Health (DH), 2010 a, b; The Royal College of Nursing (RCN), 2010 a; Nursing and Midwifery Council (NMC), 2010; DH, 2012 a, b; Nursing Standard and the Patients Association, 2012; The National Institute of Health and Clinical Excellence (NICE), 2012; DH, 2014).

These emerging political and professional endeavours to reaffirm compassion, led to a personal journey to uncover a more detailed understanding of what compassion in nursing involved. An initial exploration of the literature unearthed a variety of evidence focusing on conceptual analyses, political policy, professional guidance and opinion papers, the majority of which provided an insight into compassion from the professional perspective. However, there was a limited range of empirical evidence relating to perceptions of compassion, particularly in terms of what individuals who had personal experience of nursing care perceived it to involve. This highlighted that current knowledge of compassion in nursing was strongly influenced by professional perspectives, with limited insight from the individual perspective. As a result, I embarked on a phase of reflection to consider a range of personal questions about compassion (Figure 1).

Figure 1: Emerging Personal Questions



Engagement strategies to understand individual experiences and identify what really matters to people, is advocated as a means to enhance nursing practice by placing the person at the heart of care (DH, 2005 a, b, c; DH, 2007). However, despite acknowledging the importance of the person as the central focus of care, contemporary empirical evidence relating to compassion did not seem to reflect this. Exploration of the literature identified that there was a lack of corroboration from the individual perspective. As my research journey has progressed, this lack of insight into compassion from the individual perspective of those who have experienced nursing care has largely remained unchanged, with only a limited range of additional empirical evidence emerging recently. Schantz (2007) identifies that there is a dearth of empirical evidence pertaining to compassion overall, purporting that the feasibility of practising compassion should be questioned in the absence of a clear understanding of what it involves.

Claims have emerged to suggest that the moral dimension of compassion has been eroded by the advancing modernity of practice to such a degree, that many nurses find it increasingly challenging to demonstrate compassion, often considering it to be merely a discretionary aspect of the role (Burdett Trust for Nursing, 2006; Schantz, 2007; Georges, 2013). As a professional nurse myself, the idea that practising compassion in nursing is discretionary, rather than a core and essential value permeating all aspects of care, falls far out with my personal philosophy of nursing. In fact, I hold the position that compassion should be central to all aspects of nursing care practice. Due to this personal belief that compassion is integral to nursing, I resolved to develop a clearer understanding of it. This influenced my decision to engage in this doctoral research, with the aim to generate an original contribution of knowledge to advance the existing evidence base and provide enhanced understanding of compassion within the context of nursing.

Given the fact that there was a wide range of existing knowledge from the professional stand point, I concluded that it was important to research compassion from the individual perspective. This decision stemmed from a personal desire to enhance contemporary understanding of compassion from a more balanced position, striving to ensure that the individual was the central focus of nursing care. To achieve this, the research needed to be focused on the perceptions of individuals who had experienced nursing care and were able to discuss compassion as a result. Although the value of the professional perspective of compassion is acknowledged to be important, it is undoubtedly of equal importance to understand compassion through the perceptions of those individuals who have experienced it personally. The

impetus for this research was additionally underpinned by a personal resolve to uncover a more detailed understanding of compassion through empirical research methodologies, which were largely absent from the literature at the outset of my journey. Thus, the aim of this research is to provide an original contribution to knowledge and advance the contemporary existing evidence base to enhance understanding of compassion in nursing, from the perceptions of individuals who have personal experience of nursing care.

1.3 Clarifying Key Terminology

It is important to articulate clear definitions of key terminology used within the context of research, in order to avoid misinterpretation and ambiguity (Henn, Weinstein and Foard, 2009). To enhance clarity, the following section provides brief definitions of the terms ‘individuals’, ‘nurse’ and ‘nursing’ as they are applied throughout this thesis and in particular, how they are applied within the context of the overarching research question.

1.3.1 Individuals

In the context of this thesis, the term ‘individuals’ is primarily used to denote human beings who have encountered a personal experience of nursing care. The term encompasses experiences that may have arisen through a vicarious position, as in the context of observing or witnessing the care delivered to others.

1.3.2 Nurse and Nursing

In the context of this thesis, the term ‘nurse’ is primarily used to denote Registered Nurses and the term ‘nursing’ is primarily used to denote care delivered by Registered Nurses within formal care contexts.

1.4 Overview of the Research

1.4.1 Research Question

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

1.4.2 Research Objectives

- To explore individual experiences of care to elicit perceptions of what compassion involves.
- To uncover particular nursing care activities, behaviours, qualities or characteristics that may be perceived to be compassionate.
- To explore the potential for contexts and environments of care to influence experiences of compassion.
- To develop a propositional grounded theory which offers an original contribution to understanding compassion in nursing.

1.4.3 Research Approach and Design

The research is implemented within the interpretivist paradigm. This paradigm presupposes that reality is not fixed, rather it is dynamic and subjective, constructed by individuals within the context of their social environment (Polit-O'Hara, 2004). Interpretive approaches to research aim to understand reality as it is perceived at the subjective level of personal consciousness, and from the individual perspective (Burrell and Morgan, 1979). This approach is founded on taking the meanings and interpretations of individuals to generate understanding of the social world, and uncover knowledge which is grounded in symbolic meaning and constantly modified by a process of social interaction. The social world is claimed to be, the world as interpreted and experienced from the inside by its members (Blaikie, 2000). In order to uncover this, an ontological position of relativism and an epistemological position of subjectivism is required (Creswell, 2007).

The theoretical tenets of symbolic interactionism (Mead, 1934; Blumer, 1969) and social constructionism (Berger and Luckman, 1966; Burr, 1996; Gergen, 1999) provide underpinning influences to inform the thesis. Symbolic interactionism is a theoretical perspective which focuses on social interaction and ensuing individual interpretations of the world as a direct result of this. Socially constructed knowledge is that which is derived from the conceptualisations and interpretations of individuals in relation to their own experiences and actions, the actions of others and the context or situation in which this occurs. These two theoretical perspectives are complementary, providing a platform on which to found an interpretative research design to elicit subjective perceptions and generate new insights and knowledge (Clarke, 2005; Gardner, Fedoruk and McCutcheon, 2012).

In order to fulfil the philosophical tenets of interpretivism, symbolic interactionism and social constructionism, a constructivist grounded theory methodological research design is implemented. This methodology facilitates the development of mutual understanding of phenomena, via a collaborative relationship between researcher and participant to construct new knowledge (Charmaz, 2006, 2014). Acknowledgement of the researcher's existing prior knowledge, experience and insight is key (Hunter *et al.*, 2011). The constructivist approach to research assumes a relativist ontology which acknowledges multiple realities, a subjectivist epistemology which supports the co-construction of knowledge between researcher and participant, utilising naturalistic methodological procedures to uncover this (Denzin and Lincoln, 2003).

The notion that individuals construct their own personal and subjective perceptions of compassion through ongoing interactions in the social world influences this study. This reflects my personal worldview, which has been influenced by previous experiential knowledge gained throughout my professional career in nursing and personal experiences of compassion. Furthermore, the notion that knowledge is generated by a process of co-construction between researcher and participant, establishes an important principle of the work and underpins the rationale for the research approach and design that is implemented. I was fully aware that my extensive professional experience as a Registered Nurse and Registered Midwife, personal experience of care and vicarious observation of care delivered to family members, had undoubtedly influenced my personal perceptions of compassion in nursing. As a result, it was clear that I was unable to truly separate myself from this and enter the field devoid of any pre-existing knowledge. Acknowledging this was instrumental in guiding me to implement a constructivist grounded theory approach. Chapter 3 progresses the discussion of the underpinning theoretical tenets, methodological approach and research methods further.

1.5 Organisation of the Thesis

In order to provide clarity to the organisation of this thesis, the following section delineates and summarises the entire work via an abridged synopsis of the content of each chapter that follows this introductory chapter.

1.5.1 Chapter 2

Chapter 2 presents a comprehensive review of a wide range of relevant literature that contributes to informing understanding of compassion in the context of nursing. The literature review is founded on a stepped approach, comprising initial and focused

phases which are presented within the overarching themes of contextualising compassion and understanding compassion. This stepped approach is commensurate with the key principles of grounded theory research. The chapter establishes a gap in the literature, which the research question aims to address and the propositional grounded theory that was constructed from this research aims to fulfil.

1.5.2 Chapter 3

Chapter 3 clarifies the approach taken to develop the conceptual framework that underpins this thesis. The philosophical and theoretical tenets of interpretivism, symbolic interactionism and social constructionism introduced earlier are expanded on. The research methodology of classic and constructivist grounded theory is discussed in detail and an overview of key research methods outlined. The chapter makes explicit the beliefs and assumptions influencing the research in relation to my personal worldview, the ontological basis of the nature of reality and the epistemological basis of determining an appropriate research strategy. The concept of reflexivity is introduced, and a reflexive activity to establish both my position and that of the participant sample is provided.

1.5.3 Chapter 4

Chapter 4 provides a rigorous account of the research journey that was undertaken, discussing implementation of the constructivist grounded theory research methods that are introduced in Chapter 3. This includes consideration of issues such as ethics, the target sample population, initial and theoretical sampling, data collection, data analysis, constant comparative analysis, theoretical sensitivity, theoretical saturation and trustworthiness. The chapter concludes with some key examples of the reflexive activity that was implemented throughout the course of the research journey.

1.5.4 Chapter 5

Chapter 5 presents the findings from the research and introduces four major categories and a core category, which represent participant perceptions of compassion within the context of nursing. The findings are supported solely by participant quotations which are extracted from the data. No extant literature is used throughout this chapter, as the aim is to ensure that the individual voice is heard. The data categories are conceptually advanced through the implementation of a reflexive approach. Subsequently, five elements of compassion and a triad of principal dimensions of compassion are introduced as concepts of emerging significance. These concepts provide an influential contribution to the construction of the grounded theory that is proposed in Chapter 6 of the thesis.

1.5.5 Chapter 6

Chapter 6 reiterates the research question and objectives and provides a summary of the research findings. The five elements of compassion that were introduced in Chapter 5 are discussed in detail, following which the propositional grounded theory that was constructed from the research is presented. This grounded theory incorporates the triad of principal dimensions of compassion, also introduced in Chapter 5. The grounded theory is presented as *The Model of Compassion for Humanising Nursing Care*. This model is grounded in the research findings and provides an abstract representation of participant perceptions of compassion within the context of nursing. Implications for practice emerge throughout the discussion and a series of recommendations are proposed to address these. The originality of the grounded theory is elucidated within the context of contemporary knowledge throughout, and the chapter concludes by considering the limitations of the research.

1.5.6 Chapter 7

Chapter 7 provides a summary of key aspects of the thesis, reiterating significant points that have been elicited throughout the discussion presented in previous chapters. This chapter concludes the thesis with some final thoughts in relation to the way forward for compassion.

1.6 Chapter Conclusion

This introductory chapter has established the primary impetus for engaging in the research, providing a detailed personal rationale to support this. This clarified some relevant background information in relation to the context of my professional and personal experiential knowledge of compassion in nursing, and my subsequent position as a researcher. Compassion was briefly situated in the context of nursing and a gap in the literature briefly identified to justify the focus of the research presented in this thesis, these concepts are revisited in detail in Chapter 2. The overarching research question and objectives were presented, definitions provided relating to the use of the terms ‘individuals’, ‘nurse’ and ‘nursing’, and a brief overview of the research approach and design introduced. An overview of the organisation of the thesis provided a summary of the overall thesis content and a representative outline to delineate the work.

Although it is essential for researchers to justify the impetus for research from a personal perspective, it is also essential to move beyond this. This involves considering the significance of the area of interest to clarify what is already known about the topic in terms of contemporary evidence, and establishing a robust rationale to support engaging in research to enhance this further (Ravitch and

Riggan, 2012). The following chapter therefore presents a comprehensive review of relevant literature to address this.

Chapter 2: Reviewing the Literature

2.1 Chapter Introduction

Chapter 1 established the primary impetus for the research presented in this thesis, providing a detailed supporting personal rationale and briefly situating compassion within the context of nursing. The primary research question and objectives were outlined, key terminology was clarified and an overview of the research approach and design provided. This chapter presents a comprehensive review of a range of relevant literature and empirical research. Commensurate with grounded theory research, a stepped approach was taken to review the literature, which is clarified below.

This chapter presents a collation of the literature that was reviewed during the course of the research journey. It is delineated into two main sections to focus on issues identified to be of relevance, and presented within the overarching themes of contextualising compassion and understanding compassion. The chapter identifies a gap in the evidence base that currently informs compassion in nursing, which the research question identified in Chapter 1 aims to address. This literature review offers further credence to support the impetus and rationale for research that was presented earlier, in addition to introducing a body of knowledge which informs the thesis in its completed form.

2.2 Adopting a Stepped Approach to the Literature Review

Although it is recognised that the original tenet of grounded theory supports entry to the field in a state of ‘tabula rasa’ (Glaser and Strauss, 1967), the constructivist

approach acknowledges that this is not possible. Rather, it is accepted that researchers come to the field with prior knowledge and experience, which can influence and contribute to the construction of new knowledge (Clarke, 2005; Charmaz, 2006, 2014). In order to obtain ethical approval, it is often essential for researchers to demonstrate their level of scholarship by providing a clear justification for engaging in research, that is founded on contemporary literature. As a result, the development of a research proposal often proves challenging to doctoral students planning to implement grounded theory methodology, due to the academic requirements to analyse extant literature (McGhee, Marland and Atkinson, 2007). Experiencing a similar challenge, I therefore sought guidance to address this through an exploration of the grounded theory methodological literature.

Elliot and Higgins (2012) propose that, in the first instance, researchers utilising a grounded theory approach conduct a preliminary review of the literature to provide a basic orientation to the area of inquiry. This facilitates a stepped approach, whereby an initial search contextualises the area of investigation and supports a rationale for implementation. This is followed up by conducting further literature reviews of unpredicted, emerging concepts which are integrated into the work as the research progresses (Urquhart, 2013). The notion of delaying a comprehensive literature review until data collection and analysis is complete, is supported by Charmaz (2006). This ensures that the research findings emerge from the data, rather than being influenced by extant literature. This strategy is founded on the need to avoid preconceived ideas contaminating the work, thereby facilitating the emergence of the researcher's constructs and ideas as a direct result of data analysis. The focused

phase of the literature review should be tailored to reflect key concepts that have emerged throughout the research process (Charmaz, 2014). Delaying a comprehensive focused literature review through a stepped approach, therefore offers researchers the opportunity to derive knowledge directly from the data to support construction of the emergent grounded theory (Charmaz, 2006, 2014).

In order to fulfil the key tenets of constructivist grounded theory, a stepped approach to the literature review was therefore adopted. The literature review was undertaken in the format of initial and focused phases, and integrated into the thesis periodically as the research progressed. At the outset of my doctoral journey, an initial literature review was undertaken to contextualise compassion in nursing and identify a gap in the literature. This involved exploring literature relating to the historical origins of compassion, reported negative experiences of compassion and political and professional reaffirmations of compassion. The initial literature review supported the primary application for approval to engage in the research, commensurate with the philosophy of maintaining ethical research practice (Beauchamp and Childress, 2008). Nevertheless, I was clear in my approach that I did not wish this initial literature review to influence the analysis of the research data. Hence, any empirical research which was inadvertently located at the outset relating to perceptions of compassion, was reviewed and integrated into the thesis only once data collection and analysis was complete.

As the research progressed, additional searches to locate and review contemporary evidence to enhance the initial phase of the literature review have ensued to maintain

the currency of the work. Post data collection and analysis, a more focused literature review was undertaken to specifically explore perceptions of compassion and a range of concepts of relevance which emerged throughout the research process. Both the initial and focused phases of the literature review have been integrated into this chapter, providing a context to facilitate detailed discussion of the relevance of this evidence to the emerging grounded theory that is presented later in the thesis.

2.2.1 Search Strategy

The preliminary initial search strategy was conducted using the university 'NORA' power search engine tool, which searches multiple databases and the library catalogue simultaneously. Databases such as Cinnahl, Medline, Proquest, Internurse, Wiley and Science Direct are included in the power search. The primary key words used in the initial phase were: *compassion*, *compassionate* and *compass**, in order to yield maximum results. The search identified these terms from the title, abstract, main body or from key search words defined by authors, no date restrictions were implemented. Multiple results were initially located: *compassion* (433,865), *compassionate* (222,735) and *compass** (1,055,645), therefore the search was refined.

Databases were searched individually, to locate results which contained the defined search terms in the title, abstract or key words identified by the author, thus limiting the volume of returns. For example, Science Direct yielded the following journal articles and books across all disciplines: *compassion* (4,868), *compassionate* (3,683), *compass** (24,160). When this search was limited to the discipline of nursing and health professions, the following results were yielded: *compassion* (769), *compassionate* (569), *compass** (1653). Further searches were limited to regulate the

date ranges, as updated searches were performed during the course of the research to maintain the currency of the initial phase of the literature review. Returned results highlighted a range of conceptual analyses, discursive commentaries and professional and political literature, with a limited array of empirical research pertaining to perceptions of compassion noted. Additional literature was located via a snowball technique, identifying evidence used in the reference lists of key papers. Ongoing 'Zetoc' alerts were also used to locate evidence that used the term compassion in the title or abstract, from a wide range of international journals. Following data analysis, the focused phase of the literature review was conducted to explore key concepts of emerging relevance, using a similar method to that already described. A further search phase ensued to locate evidence relating to the philosophical and theoretical tenets, methodology and research methods. Figure 2 provides examples of key search terms used in all phases of the search strategy.

Figure 2: Phases of the Search Strategy

Initial Phase
Compassion; Compassionate; Compass*; History of Compassion; Christianity and Compassion; Compassion in Nursing; Experiences of Compassion; Compassion in- NHS, Care Homes, Private Sector; Compassion- Policy, Professional Guidance
Focused Phase
Definitions of Compassion; Perceptions of Compassion-professional, individual, patient; Personality Theory/Traits; Personal Attributes of the Nurse; Ideal Nurse; Qualities/Characteristics of the Nurse; Person Centred Care; Relationship Centred Care; Learning about Compassion-childhood/early years, nursing, care context, clinical environment; Human/ising Approaches; Influences on Compassion-staffing levels, technology, leadership.
Philosophical Principles, Methodology and Methods Phase
Qualitative Research; Interpretivist/ism; Grounded Theory; Constructivist Grounded Theory; Symbolic Interactionism; Social Constructionism; Social Constructivism; Theoretical Sampling; Data Collection; Interviews; Focus Groups; Data Transcription; Audio Recording; Data Analysis; Grounded Theory Coding; Theoretical Sensitivity; Constant Comparative Analysis

2.3 Contextualising Compassion

This section of the chapter introduces a range of literature to contextualise compassion in nursing, providing background information to support the primary impetus for research. In the first instance, the concepts of theological, early nursing and contemporary nursing influences on compassion in the UK are explored. This provides an insight into the historical origins of compassion and situates it within the context of nursing. An overview of reported negative experiences of compassion in the NHS and private care contexts is presented. This clarifies the emerging challenges to professional nursing practice, drawing upon some case study examples to illustrate individual experiences. This is followed by an exploration of the political and professional influences that have emerged in response to such negative experiences, which reaffirm that compassion remains a core philosophy of contemporary nursing practice.

2.3.1 Theological Influences on Compassion

Kapelli (2008 a, b) claims that the construct of the Compassionate God and how He is represented in Christian scripture, is that which underpins the core philosophy of compassion in nursing today. To investigate this, a systematic hermeneutical text analysis was implemented, a strategy used in historical and theological research to explore and interpret the lived experience (Van Manen, 1990). Christian scriptures were selected from a variety of sources which illustrated examples of God representing the essence of compassion. The parable of the Good Samaritan from Luke (10: 25-37) was highlighted as a significant influential narrative, which was used as a means to teach Christians to be compassionate in their actions (Figure 3).

Figure 3: *The Parable of the Good Samaritan*

25 On one occasion an expert in the law stood up to test Jesus. "Teacher," he asked, "what must I do to inherit eternal life?"
26 "What is written in the Law?" he replied. "How do you read it?"
27 He answered, "Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind; and, Love your neighbour as yourself".
28 "You have answered correctly," Jesus replied. "Do this and you will live".
29 But he wanted to justify himself, so he asked Jesus, "And who is my neighbour?"
30 In reply Jesus said: "A man was going down from Jerusalem to Jericho, when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead.
31 A priest happened to be going down the same road, and when he saw the man, he passed by on the other side.
32 So too, a Levite, when he came to the place and saw him, passed by on the other side.
33 But a Samaritan, as he travelled, came where the man was; and when he saw him, he took pity on him.
34 He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him.
35 The next day he took out two denarii and gave them to the innkeeper. "Look after him," he said, "and when I return, I will reimburse you for any extra expense you may have".
36 "Which of these three do you think was a neighbour to the man who fell into the hands of robbers?"
37 The expert in the law replied, "The one who had mercy on him". Jesus told him, "Go and do likewise".

Luke (10: 25-37)

Kapelli (2008 a) purports that the underpinning philosophy of the parable of the Good Samaritan provides guidance to followers of the Christian faith to demonstrate compassion to all those who may be distressed or in need. The Good Samaritan exemplifies the ideal role model for compassion (Leget, 2015), providing an inherent message that compassion should be the universal standard shown to all as an integral aspect of all caring practices (Tuckett, 1999; Arbuckle, 2007). This key message is exemplified in the Golden Rule "*always treat others as you would wish to be treated*

yourself”, as the key philosophical message of Christian scripture (Armstrong 2011, p1). The parable of the Good Samaritan represents the Christian God as a compassionate being, challenging followers to imitate these attributes, qualities and acts of compassion throughout daily life (Davies, 2001; Kapelli, 2008 a). The Christian influence on compassion is also evident through multiple biblical extracts which exemplify compassion through the work of Jesus, illustrated in narratives presented in the New Testament (Lomas, 2015; Jones and Pattison, 2016). The theological tradition of compassion continues to be apparent through the work of Christian Orders across the world, whose primary mission is to engage in acts of caring for the sick to demonstrate an ongoing commitment of faith (Caldersisi, 2013).

Contemporary Christian literature perpetuates compassion as the core and underlying principle of the faith, promoting examples to illustrate how followers should demonstrate compassion through acts of caring for the sick or those who are in need (Stearn, 2015; Bauman, 2016). Pope Benedict XVI (2005) draws upon the parable of the Good Samaritan as an exemplar of a holistic model that promotes concern for others across society, regardless of background. Dolan, Fitzpatrick and Herrmann (1983) highlight that the teachings contained within the Christian bible undoubtedly provided the primary impetus to situate compassion within the context of nursing. This body of religious knowledge has profoundly influenced nursing, providing a foundation from which the tradition of compassionate care of the sick has evolved (Sullivan, 1995; Kapelli, 2008 a, b). The notion that Christianity was the impetus for compassion in nursing is supported by Shelly and Miller (2006) and exemplified

through their definition of nursing. This definition identifies that nurses should be focused on the ministration of God's work, providing holistic care to promote health and provide compassion to those in need.

The evidence discussed so far indicates that in the UK, where Christianity historically dominated religious beliefs, compassion was a core theological philosophy which was exemplified by the very nature of performing caring acts. This key theological principle also underpins the core philosophies of many other religions across societies globally (Keown, 2000; Dalai Lama, 2001; De Weyer, 2003; Farah, 2003; Neusne, 2006; Armstrong, 2007; Lomas, 2015). These religious ideals have permeated the philosophy of caring roles, subsequently attributing compassion as a core philosophy of nursing. Creswell (2007) identifies that societies negotiate meaning through a process of social interaction that is driven by social norms. It is also accepted that knowledge and understanding of phenomena is influenced by culture, history and religion, all of which provide an essential contribution to knowledge and understanding of the social world (Berger and Luckman, 1966; Burr, 1996).

This led to the conclusion that Christian influences in the UK significantly contributed to the social construction of compassion as an integral component of nursing roles, as they are perceived in contemporary UK society. This claim is reflected by Shelly and Miller (2006), who declare that it is impossible to separate the profession of nursing from the Christian narrative. The following section

discusses the historical translation of compassion as a religiously driven philosophy, to clarify how it was situated within the profession of nursing.

2.3.2 Early Nursing Influences on Compassion

Prior to the establishment of nursing as a profession, caring for the sick was the responsibility of religious orders and individuals, striving to follow the word of God (Davies, 2001). As societal views moved forward, there was an ensuing shift towards moving this responsibility away from the control of religious influences, into the developing realms of professional nursing practice (Dingwall, Rafferty and Webster, 1988). As a result, nurses themselves were attributed with the challenge of meeting these historical theological ideals (Shelly and Miller, 2006). The role of Florence Nightingale and how she translated her personal Christian values to a vision of professional nursing, was instrumental in contributing to how compassion in nursing is viewed in contemporary society (Widerquist, 1992).

Caring for the sick originally evolved as a result of religiously driven motivations in a time where the Church dominated the provision of care (Shelly and Miller, 2006). Historically, in the absence of medical knowledge, the focus of care was on spiritual needs and an acceptance that health outcomes were the will of God. As medicine advanced and organised caring infrastructures evolved, care provision by religious orders in the UK waned. In the wake of the dissolution of religiously driven care provision, the role of the handywoman, private nurse and medical attendant emerged to bridge the gap (Bingham, 1979). Many of these individuals were unscrupulous, immoral, poorly educated and only interested in caring for those who had the financial resources to pay (Dingwall, Rafferty and Webster, 1988). As society began to recognise that the standard of care delivered to the poor left much to be desired,

the upper and middle classes were motivated to provide humanitarian effort to help the most disadvantaged in society (Bingham, 1979). As a result, caring for the sick became regarded as a more respectable activity, with women from privileged backgrounds undertaking missionary duties. This assumed the guise of formalised visiting schemes to promote Christian ideals, contributing to an emerging re-conceptualisation of the caring role, where spiritual care was seen to complement the developing secular approach to medicine (Dingwall, Rafferty and Webster, 1988). As medical knowledge advanced however, so did the need to offer a more formal approach to caring for the sick.

The Kaiserworth Institute for the Training of Deaconesses was the first organisation to implement a formal programme of theoretical and clinical instruction for nurses (Wentz, 1936). Florence Nightingale was among many who visited Germany to learn from them. Following her experience, Nightingale reflected that although the actual standard of nursing care provided by the Institute was lacking, the devotion and compassion of the nurses had been remarkable (Bingham, 1979). It was this experience that led her to seek an approach which balanced both the art and science of nursing, laying the foundations for the profession of nursing as it is understood in contemporary western society. On her return from the Crimean War, Florence Nightingale wrote '*Notes on Nursing. What It Is and What It Is Not*' (1859). This nursing text provides insight into her personal philosophy of nursing, identifying the conditions required to nurse the sick and highlighting the personal characteristics required of the professional nurse. There was a strong focus on the moral and

religious virtues that she deemed were required and this is illustrated in the following quote:

“she [the nurse] must be a religious and devoted woman; she must have respect for her own calling, because God’s precious gift of life is often literally placed in her hands...she should bring the best she has, whatever she has, to the work of God’s world” (Nightingale, 1859, p49).

Nightingale also discussed the concept of suffering in those who were sick, highlighting that nurses must strive to alleviate this (Nightingale, 1859). Although the word compassion was not explicitly used, the message was implicit throughout the text, nurses were instruments of God, striving to alleviate suffering through acts of compassion. Rafferty (2011) supports this notion, claiming that the philosophy underpinning ‘*Notes on Nursing*’ reflects the high value Nightingale placed on compassion. Nightingale was strongly influenced by her Christian ideals, believing that God had provided her with a calling to care for the sick (Dingwall, Rafferty and Webster, 1988; Widerquist, 1992). Her personal vocation to apply Christian values to care for the sick, was instrumental in developing her philosophy of nursing and the subsequent Nightingale image of the professional nurse (Bingham, 1979). The image of the compassionate nurse, striving to do God’s work and care for the sick of His flock was born, translated by Nightingale into the very essence of nursing. This Christian worldview was profoundly influential on her philosophy of nursing, paving the way for The Nightingale School of Nursing.

The Nightingale School of Nursing opened in 1860 with the aim of providing training to females in good health, of good moral character and who were preferably

followers of the Christian faith (McNeill, 1910; Abel-Smith, 1960). Nightingale strived to move nursing away from the image of the immoral and uneducated individual, as depicted in literary characters of the time (Dickens, 1844). Her focus was on education and demonstrating that nurses should be judged in relation to both their technical ability and personal character (Stewart and Austin, 1962). Nightingale was clear that nurses needed to develop expertise in technical knowledge and skills, together with the altruistic virtue of compassion (Maben, Cornwell and Sweeney, 2010). This ideology remains central to nursing today and is exemplified in value based recruitment (VBR) strategies, which provide a framework to support the selection of the most appropriate individuals for nursing (Health Education England (HEE), 2014 a). Nightingale's influence was instrumental in developing the image of the compassionate and skilled professional nurse of the time, therefore laying the foundations for compassion to be regarded as a core underpinning philosophy of contemporary nursing (Rafferty, 2011).

Although the caring work of Mary Seacole also provided a valuable contribution to nursing, this remained largely unacknowledged until recently. After being rejected to accompany Florence Nightingale and her team of nurses to the Crimean War, Seacole funded the journey herself. Her work with soldiers on the battlefield was celebrated at the time and gained similar accolades to those attributed to Nightingale (National Geographic, 2013). Historical accounts cite examples of her compassion, through acts to provide comfort and alleviate the suffering of soldiers on the front line of war (Blackwood, 1881, cited in Spartacus Educational, no date). However,

her contribution to nursing was overshadowed by Nightingale, reportedly as a result of inherent racial prejudices of the time (Khan, 2013).

The Nightingale effect was immense, spreading across the world and contributing to the development of the global notion of professional nursing as it is predominantly represented and understood in contemporary western societies. Her philosophy of nursing, portraying the compassionate nurse with technical competence, was perpetuated in the United States of America (USA) where The Nightingale Pledge evolved (Gretter, 1893 cited in Sweet, 2010). The pledge outlined the key underpinning principles of professional nursing, reiterating the theological ideal of serving God and devoting one's self to the compassionate care of others. The Nightingale image of the self-sacrificing angel, compassionate in nature and striving to do the work of God, is that which pervaded nursing ideologies of the time and continues to implicitly permeate contemporary nursing ideology (Hallam, 2000).

Berger and Luckmann (1966) assert that knowledge is socially constructed by a process of externalisation and objectification, resulting in the internalisation of this knowledge as a perception of social reality. The externalisation of Florence Nightingale's image of the professional nurse is indicative of how compassion has been attributed to roles associated with caring for the sick, and reflects how this ideology has been objectified in the social world. Societal objectification of compassion in nursing has continued to evolve and, as a result, society has sustained this through ongoing social practices. This has created perceptions of the social reality of the existence of compassion in nursing, internalised by society as an

integral component of caring roles today. These historical influences have also impacted the issue of gender in nursing. Nightingale's vision for nursing focused on women assuming a position of subservience to men (Sweet, 2010). Karabacak *et al.* (2012) highlight that pre Nightingale, men actively participated in caring roles. As Nightingale's vision for nursing began to pervade societal perceptions, the numbers of men in caring roles declined (Evans, 2004). Over recent years, only marginal increases in the numbers of men in nursing have been noted, with approximately 10% of the workforce currently male in both the UK (NMC, 2007) and USA (US Census Bureau, 2013).

Despite these marginal increases in the numbers of male nurses, perpetuated gender constructs continue to be a potential barrier, impacting the decisions of men to embark upon nursing careers (Muldoon and Reilly, 2003). Breaking down gender barriers and resisting dominant gender norms, can be significantly impacted by the prevailing identity of a society (McDonald, 2013). This was evident in a study of school age students in Scotland, where only 44 of 304 males indicated that they would ever consider nursing as a career, compared with 155 of 398 females (Neilson and Jones, 2012). This suggests that nursing continues to be predominantly regarded as a career pathway for females in contemporary society.

2.3.3 Contemporary Nursing Influences on Compassion

In the early part of the 20th century, the nursing role continued to be regarded as vocational, with society perceiving nurses to be devoted to the care of others. At the end of the First World War, nurse education began an evolutionary process seeking to develop standards to maintain the ethos of compassion, whilst also striving to further develop knowledge and clinical skills (Bingham, 1979). Nurse education

texts and nursing leaders of the time are reported to have sustained the notion of compassion as a core philosophy of nursing, whilst simultaneously placing increasing emphasis on technical expertise and competence (Bradshaw, 2011). This period witnessed immense change in the role as domesticity began to be superseded by technical skills, which required specialised training to support the emerging advances in medicine (Sweet, 2010). An intellectual shift began to occur, where science began to challenge traditional theological notions of compassion. As a result, Aita (2000) claims that historical values of compassion were influenced by the emerging emphasis on technical skills, perhaps overwhelming the traditional discourse and philosophy surrounding compassion.

Contemporary nursing undoubtedly requires nurses to be highly skilled, but it is essential that equal parity is afforded to maintain a balance between technical competence and compassionate values (Sullivan, 2010; Buchanan, 2013). The drive to sustain and enhance compassion is supported by many professionals, who highlight it to be an essential and integral component of nursing practice (HEE, 2014 a; Goodrich and Cornwell, 2008; Youngson, 2008, Cornwell and Goodrich, 2009; Firth-Cozens and Cornwell, 2009; Harrison, 2009; Maben, Cornwell and Sweeney, 2010). Indisputably, Florence Nightingale's vision of the nurse who strives to deliver compassionate and technical care remains relevant today. If efforts are not made to maintain the balance between fundamental values and technical skills which together, constitute the art and science of nursing, it is suggested that the very essence of nursing may wane (Schantz, 2007; Rafferty, 2011).

It is claimed that compassion in contemporary nursing has increasingly become aspirational, rather than a reflection of the everyday reality of practice (Burdett Trust for Nursing, 2006). The move from an apprenticeship based model of training (Committee on Nursing, 1972) ensued in ongoing transformational development of nurse education to professionalise nursing, resulting in the emergence of graduate level status as the required standard for contemporary practice (DH, 2010 b; NMC 2010). As these educational transformations have embedded and nursing roles evolved, this has led to suggestions that graduate nurses are ‘too posh to wash’ (Bore, 2004; Beer, 2013). Such suggestions continue to be perpetuated, as a result of some nurses perceiving that attending to fundamental care is not within their remit, transferring such care interventions to the realms of support workers (Hilton, 2006). Similar experiences have been widely reported in the media, influencing public perceptions and contributing to negative connotations, with which nurses have been increasingly associated in contemporary society (The Times, 2004; Aston, 2013).

Nurse education has witnessed further transformation over recent years, as teaching strategies have evolved in response to technological advances and role extensions (Macalister-Smith, 2013). The implementation of the ten key roles for nurses brought increasing responsibilities, with nurses required to develop expertise in advanced skills previously performed by medical staff (DH, 2002 a). The development of pre-registration nursing curricula to address the evolving role of the nurse has inevitably led to a greater emphasis on science and technology, sometimes to the detriment of compassion focused education (Firth-Cozens and Cornwell, 2009; Davison and Williams, 2009; Griffiths *et al.*, 2012). In the care context, role

extensions have increasingly impacted the nurse's ability to implement direct care, with support workers who often lack the requisite knowledge and skills, bridging this gap (Cavendish, 2013). As a result, fragmentation of nursing care has ensued, creating the potential for missed opportunities for nurses to interact and engage with the individuals for whom they are caring (Cho and Yun, 2009; Duffield *et al.*, 2012; RCN, 2012 a; Aston, 2013; Ball *et al.*, 2013).

Undoubtedly high quality clinical nursing care is of the utmost importance, but this requires balancing with the art of nursing. The Willis Commission (RCN, 2012 b) highlights that advances in nursing practice have contributed to a diminishing sense of the significance of compassion. As a result, it has been identified that compassion and clinical skills need to be addressed with parity, as integral components of nurse education curricula. The cumulative effects of the changing landscape of nursing suggests that the challenges that have emerged as the profession has advanced, may have contributed to an emerging potential for a lack of compassion. This has been evidenced through an array of reported negative experiences of nursing care. A review of a selection of these experiences is presented in the following section.

2.3.4 Negative Experiences of Compassion in the NHS Care Context

Compassion has historically been regarded as an integral philosophy of nursing, evident in seminal theories which identify it to be a core component of caring practices (Leininger, 1984; Roach, 1984). However, as the profession of nursing has advanced to maintain pace with contemporary clinical practice developments, positive discourse surrounding compassion seems to have become somewhat diminished (Firth-Cozens and Cornwell, 2009; RCN, 2012 b). Although there are positive experiences of compassion evident in the contemporary literature

(Macmillan Cancer Support, 2015; McGhee and Pearson, 2015), such positive narratives seem to have been overwhelmed by the emerging range of negative experiences. These high profile negative experiences have ensued in a perceived ‘moral panic’ (Marsh and Melville, 2011), sensationalising the emerging issues across society (Hewison and Sawbridge, 2016) to suggest an incipient lack of compassion in nursing overall. As a result, what was traditionally accepted as an expected and universal aspect of nursing, has been called into question (Mooney, 2009), with claims that compassion in nursing is merely aspirational (Burdett Trust for Nursing, 2006).

In a survey of 66,000 hospital inpatients, 1500 reported a negative experience of care which they identified to be lacking in compassion (Care Quality Commission, 2011 a). Although only a minority of respondents identified such a negative experience, the fact that individuals perceived experiences of compassion to be negative at all is of significant concern to the profession. Proctor (2008) suggests that in the majority of cases nurses are striving to deliver care with compassion, with numerous positive anecdotes of this evident across the profession. However, increasing numbers of examples of both organisations and individuals failing to meet expected professional standards, have begun to emerge over recent years. It is such examples that have been highlighted in the media, as evidence of nursing care which lacks the most basic and fundamental ethos of compassion.

The Patients Association (2009, 2011) highlighted serious concerns about failures in nursing care, through a collection of reported negative experiences which suggested

a lack of compassion in nursing. This collection of negative experiences uncovered striking similarities, particularly in terms of highlighting a lack of the most basic levels of care and compassion. The Patients Association (2009, 2011) suggested that these negative experiences were only the tip of the iceberg, claiming that the problem was far more widespread. The patient stories within the reports are very emotive, indicating inadequate levels of care and compassion which diverge immensely from the established philosophies and values underpinning the profession of nursing. A selection of summarised case examples from the reports are presented in Figure 4 to illustrate this.

Figure 4: Summarised Cases

The story of Leslie Kirk highlighted that he was prevented from seeking pain relief, as his call buzzer was deliberately removed due to nursing staff perceptions that he was seeking attention too often.

The story of Florence Elizabeth Weston indicated that she was told by nursing staff to urinate in her bed, as her condition prevented access to the toilet facilities as she was immobile following a fall which had resulted in a fractured neck of femur.

The story of Ann McNeill, a former nurse herself, provided further evidence of a lack of compassion as her relatives reported that she was left to lie in her own vomit and faeces.

The story of Sally Abbott-Sienkiewicz, diagnosed with metastatic lung cancer, identified that she was unacceptably left in pain, when she was in the last hours of her life.

The story of Joyce Jones highlighted that she lost over a stone in weight during a hospital stay, as her nutrition and hydration needs were neglected by the staff 'caring' for her.

Adapted from: The Patients Association (2009, 2011)

The Patients Association (2009, 2011) asserted that these experiences demonstrated a blatant disregard for dignity and a failure to acknowledge humanity, resulting in

nursing care which clearly lacked compassion. These examples comprise only a minority of a much broader array of negative experiences, which have unfortunately continued to emerge over recent years.

The Mid Staffordshire NHS Foundation Trust Inquiry (2010 a, b) published the findings of an investigation to explore a series of concerns about care received by inpatients during the period January 2005 to March 2009. During the investigation, witness testimonies provided persuasive evidence to support these concerns, due to similarities across individual accounts. The testimonies provided significant evidence to corroborate instances of inferior nursing care, reflecting an inherent lack of compassion from nurses. As a result, it was concluded that the standard of nursing care was appalling, ensuing in a lack of compassion and inhumane treatment of individuals who were at their most vulnerable, and often in the last days of life. It was also indicated that in some instances it appeared that the staff themselves, were uncaring and uncompassionate. However, it was identified that in the majority of cases, low staffing levels and the underlying organisational culture, had impacted on the nurse's ability to perform the role with compassion.

Further examples of negative experiences were evident in a report by The Parliamentary and Health Care Ombudsman (2011). Ten case study investigations identified the experiences of individuals who had received extremely poor levels of nursing care, all of which reflected a lack of compassion. Although the report acknowledged that many nurses working in the NHS undoubtedly deliver care with compassion, Abraham (2011) suggested that this was not universal. The report

identified recurring themes, highlighting the failure of NHS organisations and nurses to deliver care which reflected the core values and principles of the NHS Constitution (DH, 2010 a). Of the ten case studies presented, nine individuals died during, or shortly after the events. The circumstances leading to these tragic outcomes were noted to have contributed immensely to their family's distress (Abraham, 2011). One example stood out significantly on a personal level, as it occurred during a transfer to a care home in the locality of my own practice (Figure 5).

Figure 5: The Case of Mrs H

Mrs H was an 88-year-old lady who had communication difficulties due to being deaf and partially sighted, but despite this she had been an active member of her community, instrumental in founding the local Institute for the Deaf. Following a lengthy hospital stay, Mrs H was discharged by ambulance from a hospital in the Midlands to a care home in the Tyneside area, accompanied by a male nurse. On arrival at the care home, Mrs H was noted to be distressed and agitated, several injuries and bruises were evident on her body, she was soaked with urine and wearing clothes that did not belong to her which were held together with paper clips.

Adapted from: The Parliamentary and Healthcare Ombudsman (2011)

As I reflected on this particular case, the events significantly affected me on an emotional level as a nurse, as an academic, and also as a human being. With striking similarity to The Patients Association (2009, 2011), the report highlighted a disregard for the very fundamentals of dignity and compassion, from nurses who were charged with the responsibility to care for vulnerable individuals in need. The Parliamentary and Health Care Ombudsman (2011) identified that the case studies were indicative of both individual and organisational failures to recognise individual humanity and facilitate compassionate responses, reflecting the indifference of staff

attitudes to deplorable standards of nursing care. Following a series of Care Quality Commission inspections to monitor standards of care for older people (CQC, 2011 b), similar claims about the indifference of nurses were noted, with suggestions that failures in compassion could largely be attributed to negative staff attitudes and task focused, rather than person focused, approaches.

In the majority of reported negative experiences publicised to date, the individuals involved have been noted to be largely from the older population. However, there is emerging evidence that failings in compassion are not confined to the older age group, as instances of nursing care which are lacking in compassion have also emerged from experiences within the younger age groups. Examples of nurses failing to introduce themselves, assuming a task focused approach and neglecting fundamental human needs illustrate a clear lack of compassion (Youngson, 2008; Granger, 2015). This suggests that a lack of compassion in nursing is not confined to the experiences of older individuals. In fact, it suggests that experiences of compassion in nursing can be variable for a diverse range of individuals, across a diverse range of care contexts. This is evidenced by similar negative experiences encountered by individuals within the private care context.

2.3.5 Negative Experiences of Compassion in the Private Care Context

Tingle (2011) states that negative experiences of nursing care reflect an endemic failure of the NHS. Yet, these failures do not appear to be confined to the NHS, and are also evident across a variety of other care contexts. The British Broadcasting Corporation (BBC, 2011) highlighted the systematic abuse of residents with learning disabilities in a private assessment unit in the documentary '*Winterbourne View: The Hospital that Stopped Caring*'. The documentary identified harrowing issues

involving the frequent abuse of residents and the use of inappropriate restraint techniques as common practices within the organisation. A subsequent investigation corroborated this widespread poor practice, demonstrating the need for significant change to promote a positive organisational culture to facilitate compassion (DH, 2012 a).

Chubb (2013, a, b, c) highlighted inherent failings in compassion in the private care home sector. Examples were provided of fundamentally abusive practices, involving residents being left in their own excrement, subjected to rough handling techniques, being inappropriately medicated and experiencing a high incidence of falls. After care home inspections in 2012, The Care Quality Commission (CQC, 2013 a) also identified concerns of a failure in compassion, following significant numbers of hospital admissions from care homes due to avoidable conditions such as dehydration, malnutrition and fractures following a fall. Concerns relating to abusive and neglectful practices were also highlighted in a high profile documentary '*Behind Closed Doors: Elderly Care Exposed*' (BBC, 2014). This uncovered additional evidence of nursing care that was lacking in compassion within the private care sector, occurring in the experiences of the most vulnerable of individuals in UK society.

Additional reports have suggested that the provision of home care in the private residences of individuals, have also been affected by a fundamental lack of compassion. Following the inspection of 250 home care agencies, the Care Quality Commission reported that in a quarter of cases, concerns had arisen regarding levels

of compassion as a result of a failure to meet expected standards of care. Statements from individuals proclaiming that they simply felt like a ‘number’, contributed to the overall sense that compassion was not always an integral component of practice. As a result, recommendations were made to highlight the necessity for staff to build effective relationships with the individuals they were caring for, through person focused practices which acknowledged the need for respect and dignity (CQC, 2013 b).

This overview suggests that many of the examples arising from within the private sector, have resonance with those arising from within the NHS. It provides supporting evidence to suggest that negative experiences of compassion in nursing are apparent within, and across, a varied range of care contexts and age groups. Goodrich and Cornwell (2008) suggest that in complex organisations which are constantly experiencing development, change and modernisation, there is a regrettable potential for uncompassionate care. In fact, the seminal work of Durkheim (1947) suggests that in large and complex organisations, traditional collective norms and values risk being diluted due to the vast numbers of individuals responsible for sustaining established organisational principles and processes. Even when faced with the challenges of achieving high standards within the realms of ongoing change in the complexity of caring organisations, it is contended that compassion should remain an integral and core philosophy of nursing and caring professions (Goodrich and Cornwell, 2008).

Since these reported negative experiences do not seem to reflect isolated or infrequent events, this indicates that compassion in nursing requires due consideration. Ongoing emerging evidence from a variety of sources throughout my doctoral journey suggests that some individuals continue to encounter negative experiences of nursing care which lack compassion. Online patient stories from internet sources such as Health Talk (no date), illustrate examples of individuals often failing to experience compassion as an integral component of care. In the media, the most extreme and harrowing examples of nursing care which lacks compassion, continue to gain high profile. A recent example of this provided video footage of care home support workers torturing the comfort dolls of residents with dementia, resulting in extreme psychological distress for the individuals involved (Spanswick, 2016). These examples contribute to a developing lack of trust and confidence in the profession, and inevitably influence public perceptions of compassion within the context of nursing.

This developing lack of trust is compounded by the world wide web, which is a further influential source on public opinion in a society that has immediate access to information (Papacharissi, 2002; Savigny, 2002). The news headline '*Humanity Washed Ashore*' informed the world about the fatal plight of a three-year-old Syrian child. The impact of this was immense, generating an almost instantaneous worldwide public outcry for a compassionate and humane approach to the treatment of migrant refugees (Mail Online, 2015). This demonstrates the powerful influence of the media in a globalised society where information is readily accessible and thus, has the potential to alter public perceptions of the nursing image (Rezaei-Adaryani,

Salsali and Mohammed, 2012). This gives rise to challenges in sustaining public confidence in historically accepted ideals that nurses are inherently moral and good, particularly when an onslaught of media coverage suggests otherwise (Tester, 2001).

Through my personal relationships, friends and relatives frequently share anecdotes about nursing care experiences which fail to demonstrate a compassionate approach. Engaging in discussions with colleagues and peers raises similar anecdotal insights. In response to such negative public perceptions, a range of drivers from the political and professional domains have emerged to address these contemporary challenges to compassion. This has involved a clear reaffirmation to re-endorse compassion, reassuring society that compassion continues to be a core value that underpins the traditional and fundamental philosophy of nursing. The following section provides an overview of key literature to illustrate this.

2.3.6 Political Influences on Compassion

In response to the plethora of reported negative experiences of a lack of compassion in nursing, an array of literature from the political domain has emerged to reaffirm that compassion continues to be integral to contemporary nursing practice. It is claimed that political involvement in compassion seeks to address an agenda that may not be particularly conducive to the profession of nursing. Rather, it serves political interests to pronounce the demise of compassion as a failure of nursing, in order to gain public support to make revisions to matters such as employment terms and conditions (Radcliffe, 2013), undermine the value of university level education for nurses (Shields *et al.*, 2012) or promote the marketisation of health care (Hutchinson, 2016). Flynn and Mercer (2013) purport that politicising compassion is a strategy to detract public attention away from the radical restructuring and financial

austerity measures that have occurred within the NHS, in favour of focusing media attention on the alleged failures of nurses. In fact, as the NHS has increasingly been subject to financial austerity, declining staffing levels and maintaining enforced targets, nurses have been blamed for what has been labelled a ‘compassion deficit’ (Calcott, 2013; Flynn and Mercer, 2013).

The NHS Constitution (DH, 2010 a) established the principles and values underpinning the NHS and identifies the rights of patients, public and staff by the articulation of a series of pledges. One of the key NHS values relates specifically to compassion, indicating that patients should expect this as an integral component of nursing care. This key NHS constitutional commitment is further reaffirmed in the government response to the Mid Staffordshire NHS Foundation Trust Inquiry (DH, 2014):

“Compassion...we respond with humanity and kindness to each person’s pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care” (DH, 2010 a, p12).

This statement represents the essence of compassion as it was expressed following extensive consultation with key stakeholders. It is founded on the views of patients, public and staff and elicits the need for nurses to recognise suffering and actively engage in action to alleviate it (DH, 2010 a). It provides some basic insight into compassion from both professional and individual perspectives, and identifies the need for nurses to work towards upholding the pledged constitutional principles (Caulfield, 2010). However, it fails to delve further to specifically expound what compassion involves. Although government level recognition of the value of

compassion as an essential aspect of nursing is welcomed, simply acknowledging it as such is inadequate. It is claimed that politicians also need to consider the wider challenges of practice, particularly in relation to factors which may compromise the nurse's capacity for compassion (Castledine, 2009; Flynn and Mercer, 2013; Hutchinson, 2016).

The Prime Ministers Commission on the Future of Nursing and Midwifery in England (DH, 2010 b) further supported the pledge for compassionate nursing care, highlighting the role of nurses, nurse leaders and corporate boards for championing this fundamental philosophy of nursing. As a result of extensive engagement with health care professionals, stakeholders and members of the public, twenty key recommendations were made, with a strong emphasis placed on the need to ensure that nurses deliver compassionate care. Despite this emphasis on compassion, the report does not provide any real indication of what compassionate care entails. The DH (2010 b) do, however, recognise the complexity of compassion and identify that it is founded on professional approaches which are underpinned by knowledge, skills, competence and appropriate values.

Further political influences on compassion arise from support for intentional rounding, a strategy which directs nurses to implement hourly comfort rounds to assess fundamental care needs (National Nursing Research Unit (NNRU), 2012; Nursing Standard and The Patients Association, 2012). This approach aims to address potential failings in compassion, by implementing strategies to proactively identify individual needs (DH, 2012 a). However, it is suggested that rounding can

mitigate a holistic approach to nursing care, contributing to additional documentation and potentially impacting the nurse's capacity for compassion (Castledine, 2009; Fitzsimons, Bartley and Cornwell, 2011). Adopting such a structured strategy seems to favour a return to a mechanistic and task focused approach which is guided by completion of a checklist, rather than promoting a holistic and person focused approach, which is underpinned by compassion (Bradshaw, 2012). Furthermore, limited research has been conducted to date to evaluate the effectiveness of intentional rounding (NNRU, 2012). Political advocacy for the strategy therefore seems to be a reactive response to quell public dissatisfaction, in the wake of high profile media attention on the perceived 'compassion deficit' in nursing. However, simply implementing a strategy to address alleged failures in compassion is arguably fruitless in the absence of a clear understanding of what compassion involves.

Other political influences are evident in the Values Based Recruitment (VBR) Framework, mandated by government to address reported failings in care (Health Education England (HEE), 2014 a). VBR draws upon the values of the NHS Constitution (DH, 2010 a), explicitly requiring Higher Education Institutes and NHS employers to recruit potential candidates for pre-registration nurse education and post-registration positions, for their personal alignment with identified values and behaviours such as compassion. Assessing individual affinity with compassion through VBR poses a challenge, particularly given the fact that there are no clear indicators to elicit what compassion involves. HEE (2014 b, p3) acknowledge that there is limited evidence to support VBR but despite this, purport that it has utility in identifying individuals who possess values and attributes which can influence 'goal

content' and 'goal striving'. Values are thought to be influenced by motivational goals that can influence behaviour. Within this ideology, values are considered to influence an individual's choice to pursue a particular goal (goal content), whilst personality traits impact the effort an individual will implement in the pursuit of these goals (goal striving) (HEE, 2014 b). The underlying philosophy of VBR suggests that individuals actively make choices to behave in a particular way, implying that nurses themselves are solely to blame for failings in compassion (Hawkes, 2012). Although the notion of choice may be accurate to some extent, it fails to acknowledge external factors which may impact on the nurse's capacity to act in the way they would ordinarily aspire (Paley, 2014).

Porter (2006) suggests that political interventions arise from a position to maintain power and order in society, seeking to invoke public support through the demonstration of upholding electoral promises. This is extremely pertinent in the UK, where the NHS is a core expectation of contemporary society and a pivotal issue influencing individual political affinity and voting behaviour. Federman (1999) asserts that political association with compassion has immense power to profoundly influence the views of the electorate towards a favourable perception of the governing party. Politicising issues such as compassion therefore potentially exerts a powerful influence on socially constructed views, particularly given the extent of public access to information in the wake of the globalisation of modern society. Although political involvement is welcomed as guidance to enhance practice, particularly in the wake of national scandals such as the Mid Staffordshire NHS Foundation Trust Inquiry, compassion is an issue that nurses need to consider within

their own professional agenda. In addition, there is clearly a need to delineate what compassion involves, particularly if nurses are expected to implement it or be recruited for positions as a result of their affinity with it. The following section explores a range of contemporary literature relating to professional influences on compassion.

2.3.7 Professional Influences on Compassion

In response to the political reaffirmation of compassion arising from the Mid Staffordshire NHS Foundation Trust Inquiry (2010 a, b), the professional nursing arena has also made concerted efforts to reassure society that compassion continues to be a core philosophy of nursing. A selection of key literature from the professional domain is explored below to illustrate this.

The Royal College of Nursing (2010 a) contribute to the professional reaffirmation of compassion, identifying eight principles of nursing practice which highlight expected standards of care. The principles provide an overarching framework to facilitate high quality nursing care, seeking to provide a resource tool that can support nurses to demonstrate, measure and evaluate nursing practice (Manley *et al.*, 2011). The principles highlight the need for nurses to treat all those they care for with dignity, respect and humanity. Compassion is identified to be fundamental to contemporary nursing care, providing a foundation from which all nursing care practice should emerge (Jackson and Irwin, 2011). However, although compassion is highlighted as integral to nursing practice, there is no attempt to elucidate what it entails. If nurses are to implement the principles of nursing practice and strive to maintain a compassionate approach to all aspects of care, it is claimed that they

require both an understanding of compassion, and adequate support from nurse leaders to achieve this (Manley *et al.*, 2007).

The drive to reaffirm compassion as a core philosophy of nursing is also evident in the Nursing and Midwifery Council (NMC) Standards for Pre-Registration Nursing Education (NMC, 2010). The standards identify the required level of competence that student nurses must attain in order to enter the professional register, placing immense importance on compassion as an integral component of the domains of practice. Although NMC standards for nurse education have always been underpinned by compassion, this was not as explicit in previous guidance. The commitment to reaffirm compassion is further supported within additional standards for professional practice, which indicate that it is a requirement for nurses to sustain it throughout the entire career trajectory (NMC, 2004; NMC 2015 a, b). This demonstrates an ongoing commitment to compassion as a core nursing philosophy, striving to regain public trust in the nursing profession through a clear reaffirmation. However, the standards provide limited insight into what compassion involves, thus leaving nurses in a tenuous position, whereby they are professionally obligated to demonstrate compassion without a comprehensive understanding of it.

The Chief Nursing Officer furthers the professional drive to reaffirm compassion. A vision for nursing is outlined in the Compassion in Practice Strategy (DH, 2010 a), building on the core values of the NHS Constitution and positioning care champions as central to implementing it (Cummings and Simpkin, 2014). The vision provides a professional response to the political reaffirmation of compassion and outlines six

key areas, commonly termed the 6 C's, that are indicative of a mantra for good nursing practice. The principles of Care, Compassion, Competence, Communication, Courage and Commitment are highlighted as core values that require implementation across a variety of care contexts (DH, 2012 b). Since their introduction, practice developments to implement the 6 C's have gained pace, with claims that headway is being made and cultures are being changed.

In a review of progress, practice examples illustrate the integration of the 6 C's with quality outcomes, demonstrating the art and science of nursing complementing, rather than competing against one another (NHS England, 2014 a). Key examples illustrate approaches to address clinical quality and compassion with equal parity, and take into account strategies to propose new models of care to improve practice (NHS England, 2014 b). Embedding the 6 C's into contemporary practice is further supported by a framework which identifies the need for nurses to lead on approaches to improve practice. The framework aims to advance shared alignment with the fundamental values that underpin the philosophy of nursing, through a strategy which strives to add value to the outcomes and experiences of individuals experiencing care (NHS England, 2016). However, despite the positive advances made in relation to embedding the 6 C's into practice, the essence of what compassion involves is not clearly elicited and arguably, simply assumes a tokenistic approach to addressing compassion in the reality of contemporary practice.

The evidence from the political and professional domains discussed so far, identifies that compassion has been reaffirmed as an essential and integral core philosophy of

nursing. This suggests a desire to reaffirm the traditional philosophies of nursing, encouraging nurses to effectively balance the technical aspects of the role with compassion. However, it appears that much of the professional reaffirmation of compassion arises mainly in response to the political reaffirmation of compassion. These reaffirmations attempt to redress the emerging lack of public trust in nursing, arising as a consequence of high profile reports which have led to concerns about compassion as a traditional core philosophy of nursing (The Burdett Trust for Nursing, 2006; Mooney, 2009). What is evident from the preceding discussion is that although there is a clear drive to reaffirm compassion in nursing, there is limited articulation across the political and professional literature to delineate what compassion involves. In order to facilitate the implementation of compassion in practice, it is imperative that nurses understand what it entails (Olshansky, 2007; Schantz, 2007). The following section therefore reviews a range of relevant literature to explore contemporary understanding of compassion in nursing.

2.4 Understanding Compassion

Despite the political and professional reaffirmation to re-endorse compassion as a philosophy that continues to lie at the very heart of nursing, the literature reviewed in the previous section provides limited consideration of what compassion involves. Understanding compassion is complex due to the subjective, individual and unique nature of what is regarded to be such an intangible concept (Harrison, 2009; Dewar, Pullin and Tocheris, 2011). Compassion means different things to different people, and as a result, raises challenges to facilitate understanding of it (Davison and Williams, 2009). Compassion is considered to be the most precious asset of the nursing profession. Yet the concept is not clearly understood in the context of

contemporary nursing practice, and is further confused as a result of using words such as caring, sympathy, empathy and compassion interchangeably (Schantz, 2007). This raises challenges for the nursing profession in terms of understanding what compassion involves, and was a significant catalyst that contributed to the rationale to undertake this doctoral research. Throughout this section of the chapter, a range of literature is reviewed to explore the evidence base that currently informs contemporary understanding of compassion. This evidence primarily arises from conceptual analyses, discursive commentaries and empirical research. The review that follows focuses on perceptions of compassion and a range of additional concepts of significance which emerged as being of relevance throughout the research process.

2.4.1 Professional Perceptions of Compassion

The literature reviewed in this section of the thesis provides a preliminary insight into compassion from the professional perspective. Nouwen, McNeill and Morrison (1982) posit that compassion involves being empathetic to the suffering of others, entering into the realms of this suffering and reacting with a humane response. Compassion relies on emotions arising from the affective domain (Greenberg and Turksma, 2015) and thus, involves nurses exposing themselves to the suffering of others, experiencing a shared emotional response and acting accordingly to offer alleviatory action (Young-Mason, 1988; Nussbaum, 1996; Schantz, 2007). Way and Tracey (2012) assert that compassion involves three key stages which comprise recognising, relating and re(acting). This three stage process involves the ability to recognise the suffering of others, connect with the person experiencing the suffering and respond with appropriate action to alleviate that suffering. This range of evidence therefore highlights the importance of the nurse's ability to recognise

suffering in the first instance, however this can often prove challenging. In the most basic sense, dictionary definitions cite suffering to be the experience of pain or distress (Oxford University Press, 2010), but in nursing practice an individual's sense of suffering often goes far beyond this.

The concept of suffering is complex, occurring in response to a variety of factors that are unique to the individual (Tudor, 2001). In any instance of compromised health, there is an inevitable sense of loss, and the perceived and subjective level of this is an indication of the severity of an individual's suffering. This requires nurses to be attentive to the needs of others, providing compassion to address an individual's suffering at whatever level this may be exhibited, in whatever circumstances they may exhibit it (Van der Cingel, 2009). However, nurses may possess a value neutral view of suffering as a result of approaches which have traditionally promoted professional objectivity, thus impacting on ensuing compassionate actions to alleviate it (Warden, Carpenter and Brockopp, 1998). If recognition of individual suffering is an impetus for compassion, nurses must be aware that suffering can manifest itself in a variety of ways, and at a variety of levels, as a result of physical and psychosocial determinants (Tudor, 2001). To facilitate recognition of another individual's needs, the traditional professional boundaries between emotion and reason need to be blurred, leading nurses to consider compassion as not what they choose to do for patients, but what they choose together with them (Von Dietze and Orb, 2000).

Lown, Rosen and Marttila (2011) suggest that compassion is dependent on the development of empathetic relationships, effective communication strategies, inclusive partnership working and an understanding of the person as an individual. They purport that compassion is an exclusive phenomenon in its own right, positioned midway on a continuum at the intersection of the attributes of sympathy and empathy. Both of these attributes are influential to invoking compassion, acting as a catalyst to induce a human emotional response to recognise suffering or distress (Loggia, Mogil and Bushnell, 2008; Singer and Klimecki, 2014). In a study in the United States of America (USA), nurses identified what they considered compassion to involve, emphasising the importance of attributes such as empathy to support respectful interactions and a partnership approach to care (Burhans and Alligood, 2010).

A thematic analysis of data collected from 77 nurses during a consultation in the UK, further supports the importance of attributes as an antecedent of compassion (Day, 2015). Nurses identified that they perceived compassion to be dependent on the attributes of understanding, caring, empathy and listening. In addition, they suggested that compassion was founded on treating others as they would expect to be treated themselves, the key philosophy of the Golden Rule discussed earlier (Armstrong, 2011). Although providing some insight into professional perceptions of compassion, the work was not founded on a robust empirical research methodology as the data arose almost incidentally through discussion and feedback in a consultative event. The findings, therefore, have limited utility to contribute to the current evidence base that informs compassion in nursing. What they do highlight

however, is that personality traits may be a significant aspect of compassion, a concept that is explored in further detail as the chapter progresses.

Cornwell and Goodrich (2009) assert that compassion is dependent on the nurse's ability to see beyond the individual as a passive recipient of care, enabling them to see the person and their unique individuality. A phenomenological study to explore the perceptions of seven nurses in an older person's long term care facility in Canada supports this notion (Perry, 2009 a). Data was collected through interviews and observations, with analysis identifying that individualised approaches to attend to 'the little things' were an essential aspect of compassion. Nurses identified that what may be considered an insignificant intervention, was often highly significant to the perceptions of the individuals for whom they were caring. This highlighted the significance of implementing individualised approaches and developing effective interpersonal relationships as a means to facilitate compassion. However, although the research provides some empirical insight into professional perceptions of compassion, the sample size was extremely small. In addition, as the research was conducted in Canada, questions arise regarding the generality of the findings to the UK given the cultural aspects of potential differences arising from diverse systems of health care. Furthermore, the data collection strategy involved direct observation of the nurse's caring practice, which may have influenced the behaviours that were exhibited. These issues therefore require due consideration when contemplating the potential resonance of the findings to the nursing care context of the UK.

Further professional perceptions of compassion arise from the work of Armstrong (2009), an active campaigner for compassion to be embedded in everyday life through adherence to a Charter for Compassion (Appendix 2). The message of the charter identifies that society is interdependent and in order to ensure that humanity is fulfilled, compassion must be practiced as a matter of course. Although not specifically arising from the nursing domain, the key philosophies underpinning the charter have immense resonance with the profession of nursing. Key statements such as those related to treating people as human beings, affording individuals with equality and respect, meeting fundamental needs and engaging in actions to alleviate suffering and pain are of major significance, as identified from the earlier discussion in this section of the chapter. Although the charter refers to the historical origins of compassion arising from religion, the intent is not to promote any religious affiliation. Rather, the charter aims to embed compassion as an integral component of everyday secular life, a core value that is afforded to all regardless of age, ethnicity, creed or religion; a key philosophy of nursing in contemporary society.

2.4.2 Collective Perceptions of Compassion

A variety of the empirical research to explore perceptions of compassion has arisen from exploration of both the professional and individual perspective. This has culminated in representing a collective perspective, which blends the perceptions of professionals and individuals who have experienced care into one single representation of compassion. As a result, throughout this evidence it is difficult to establish from whose specific perception the findings originate. Some of the research also involves health care professionals other than nurses, further blurring the boundaries of perceptions of compassion within the context of nursing.

Van der Cingel (2011, 2014) conducted qualitative research to explore the perceptions of thirty nurses with more than five-year's experience, and thirty-one older people over the age of sixty-five with a chronic disease. The research was conducted across the care contexts of a rehabilitation centre, a home care organisation and an outpatient clinic in the Netherlands. Data was collected via a series of interviews by a researcher and a small group of student nurses, with analysis revealing that compassion was perceived to entail seven key dimensions. These dimensions related to attentiveness, listening, confronting, involvement, helping, presence and understanding. The findings identified that recognition of suffering was the primary impetus for compassion and that a range of interpersonal skills and personal attributes were associated with compassion. As suggested earlier, this indicates some affinity with the notion that personality may be a significant aspect of compassion. In highlighting the role of interpersonal skills, the research suggested that relationships may also be of significance to compassion; a concept that is explored further later in the chapter. Although the work provides some insight into compassion, it is unclear whose perceptions the findings specifically represent as they are integrated into one single collective representation. The involvement of student nurses with limited research expertise in the data collection phase raises further issues for consideration in terms of the rigour of the work, thus casting some doubt on the utility of the findings. In addition, the context within which the research was conducted raises further issues, particularly in relation to the potential cultural differences associated with nursing in the UK and the health care system in the Netherlands.

The importance of interpersonal skills was evident in a series of *Schwartz Center Round* discussions, implemented with professional care givers and individuals who had experienced care in fifty-four hospitals across the USA. From analysis of the discussions, Sanghavi (2006) noted three key themes to be indicative of what compassion was perceived to involve. These related to communication, treating the person as an individual and establishing a partnership approach to care. These findings reflect affinity with the notion that personality, individualised approaches and relationships are integral to compassion, supporting perceptions highlighted in the literature discussed earlier. However, there are issues to consider in relation to the data collection strategy, particularly in relation to the unstructured and informal nature of the discussion groups that were implemented across a diverse range of care contexts in the USA, which culturally differ from those in the UK. As limited guidance was provided to structure discussions, there is potential for differing interview techniques and inconsistencies across participant groups. This raises questions in relation to the research approach and subsequent utility of the findings. Furthermore, as the findings were presented as a collective representation of perceptions, this creates ambiguity in establishing from whose perspective the perceptions emanate.

As part of a broader practice development initiative, an appreciative inquiry was implemented to determine what constituted compassionate care in an older person's care context in Scotland (Dewar and Mackay, 2010). Data collection involved nurses, inpatients and their families, with the findings identifying that compassionate care involved knowing the person as an individual, understanding things from the

individual's point of view and assuming a partnership approach to care delivery. A working definition of compassion was constructed from the findings, highlighting the importance of recognising vulnerability, rather than suffering, and promoting the value of nurturing relationships (Dewar, Pullin and Tocheris, 2011). Promoting recognition of vulnerability is arguably of higher utility to contemporary nursing practice as undoubtedly, all those who enter into the nursing care context can be defined as vulnerable at some level.

The work affords some insight into what compassion may involve for individuals experiencing nursing care and has resonance with many of the findings already discussed. However, the research did not solely explore individual perceptions of compassion and as such, provides a collective representation of compassion that is generated from nurses, inpatients and their families. As a result, it is difficult to establish specifically, from whose perceptions the key themes originate. Although the study makes some headway in enhancing current understanding of what compassion involves in a UK nursing context, it fails to offer the more detailed insight that is required if nurses are to comprehend compassion from the perceptions of individuals who have experienced nursing care.

In the West Midlands of the UK, Kneafsey *et al.* (2016) implemented a qualitative research study with a sample of 45 participants, which included academic staff, students, clinicians and service users. Focus groups were implemented to explore how compassion could be defined and to identify associated behaviours that may be perceived as indicative of compassion. Data analysis revealed that participants

perceived compassion to be complex and not easily defined. Participants highlighted that they perceived compassion to be an intrinsic aspect of personality that was present at birth, but which was potentially subject to development through education. Compassion was defined as a combination of emotion, values and motivation to take action. Ensuring positive communication through interpersonal interactions which developed effective relationships, was also noted to be of importance. Participants also recognised wider challenges to compassion, highlighting the potential influence of systems and processes in the care context, nurses having time for compassion, the role of leadership and the influence of role modelling to support compassion in practice.

This study goes significantly further than the research discussed previously as it does not solely focus on personality, attributes and interpersonal relationships in relation to compassion. However, there is no attempt to delineate individual and professional perceptions, and as a result, one collective representative view of compassion is presented. Individual perceptions of compassion are unclear in the work, and on analysing the sample statistics it is evident that the sample was unbalanced, comprising 35 professionals and only 10 individuals who had experienced care. Hence, there is potential that individual perceptions may have been subsumed, or overwhelmed by the perceptions of professionals. This is apparent in the published work itself, as only data from the professional perspective is utilised to support the findings, with no examples of data from the perspectives of individuals who had personal experience of nursing care. Although the literature discussed so far provides a foundation on which to build current knowledge and understanding of compassion

in nursing, there is a clear and significant gap in relation to individual perceptions of compassion which is worthy of further investigation.

2.4.3 Individual Perceptions of Compassion

A limited range of research has been conducted to exclusively explore the perceptions of individuals who have experienced nursing care. The majority of that which has been implemented originates from the USA and Canada, with only one empirical study conducted in the UK identified during the literature search phase. This highlights that gaining understanding of compassion from the individual perspective requires further investigation.

Skaff *et al.* (2003) implemented quantitative research to explore individual perceptions of compassion and compare them with those of physician's assistants (PA). Ten statements from previous work to explore PA perceptions of compassion were assimilated into a Likert scale questionnaire and administered to 100 participants to rate the PA caring for them. Statistical analysis noted significance with only three of the ten statements, specifically the elements of forbearance (PA does not become irritated with the patient), consideration (PA is careful about what to say and how to say it) and explanatory communication (PA explains in more detail when the patient has trouble understanding).

It is important to consider that the ten statements and their associated definitions identified from the views of PAs, present a somewhat paternalistic view of compassion and have the potential to diminish the sense of agency of the individual experiencing care. For example, the definition associated with explanatory

communication suggests that enhanced information will only be given in circumstances where the patient 'has trouble' understanding it. Although the research provides some insight into what compassion may involve, it fails to explore the concept of compassion in terms of how it may specifically relate to nursing in the UK, as it was implemented with PAs in the USA. The inconsistencies between PA and participant perceptions of compassion are also notable, thus requiring professionals to consider that what they themselves perceive compassion to involve, is not necessarily reflective of what the individual experiencing care perceives compassion to involve. In addition, the fact that PAs collected data from the individuals they were caring for, suggests the potential for implicit power issues to influence participant responses, thus potentially limiting the utility of the findings.

Kret (2011) implemented a mixed methods research study with one hundred inpatients from a range of medical and surgical wards in the United States of America (USA). The research invited participants to respond to a single qualitative question to describe the compassionate qualities of the nurse caring for them. In all cases, participants were invited to engage in the research by the actual nurse who was caring for them, whilst they were still an inpatient in the clinical area. The qualitative data indicated that participants perceived the compassionate qualities of the nurse to include being caring, attentive, approachable and willing to keep the participant informed. With similarity to previous research already discussed, the significance of interpersonal skills and personal attributes were apparent. Participants were also invited to rate the nurse caring for them with a compassion index, which

utilised a continuum of characteristics ranging from cold-warm, unpleasant-pleasant, distant-compassionate, insensitive-sensitive and uncaring-caring.

On analysis of the data, statistical significance was noted in relation to the length of time elapsed since the nurse had qualified and an increased likelihood to exhibit characteristics at the negative end of the compassion index. This suggested that the longer the nurse had been qualified and the more experience gained, the higher the likelihood that an uncompassionate approach would be demonstrated. Kret (2011) speculated that this may be attributed to compassion fatigue, potentially arising from the stresses of being unable to fulfil the nursing role as an inevitable cost to caring (Joinson, 1992; Figley, 2002; Ledoux, 2015). Older patients were more likely to rate the nurse caring for them at the positive end of the index. This was attributed to the dependency of the older patient who may have required increased levels of care and attention, which potentially fostered enhanced levels of perceived compassion. An alternative explanation for this could relate to the potential influences implicitly exerted by the data collection strategy. As participants were being asked to rate the actual nurse who was caring for them, it is possible that concerns about giving a negative response may have had an impact on subsequent care, thus influencing participant responses and identifying a potential limitation of the study.

In a Canadian study, 53 in-patients with advanced cancer were recruited from two palliative care units and interviewed to explore their perceptions of compassion (Sinclair *et al.*, 2016 a). Seven key themes emerged from the research which related to issues associated with virtues, relational space, virtuous responses, seeking to

understand, relational communicating, attending to needs and ensuing outcomes.

Participants identified that nurses required a personality that was defined by attributes such as kindness and patience to facilitate compassion. Engagement with the individual through the development of effective relationships was required, enabling nurses to respond with actions which demonstrated skilled communication strategies and their knowledge of the person. Participants reported that they desired timely action to alleviate their suffering, within an approach which acknowledged their holistic needs. Relationship and patient centred approaches to connect with the individual were key to this, and thought to be influenced by individual dispositional and contextual factors.

These findings reflect a strong affinity with the previous research that has been explored in relation to professional and collective perceptions of compassion. They represent a more comprehensive understanding of compassion from the perspectives of individuals who have experienced nursing care. However, despite this more comprehensive insight there are some issues that require consideration. The context of the palliative care environment may have potentially influenced experiences of compassion as undoubtedly, this is the very context in which compassion would generally be expected as an integral aspect of nursing care. As a result, this raises questions about the resonance of the findings to a more generic nursing care context. Furthermore, as the research was conducted in Canada the findings need to be considered in terms of their relevance to nursing in the UK, due to potential cultural differences arising from these diverse contexts of care.

A study of 43 medical patients in the UK explored individual perceptions of nursing care, highlighting compassion to be an essential aspect of 'good' quality care. However, despite identifying compassion to be significant, the study failed to specifically explore what compassion involved (Attree, 2001). The work of Bramley and Matiti (2014) is the only identified empirical research that has been conducted to exclusively explore compassion from the perceptions of individuals who have experienced nursing care within the UK context. Ten inpatient participants, admitted for more than twenty-four hours and almost at the point of discharge, were recruited from respiratory wards within a NHS trust located in the East Midlands. Data was collected using a semi structured interview guide and interviews were conducted in a room situated within the ward environment.

A thematic approach was taken to data analysis and three key themes emerged from the data which related to knowing the person, seeing the situation from that person's perspective and ensuring effective communication. This suggests that relationships and personality factors were perceived to be key aspects of what compassion involved, offering further support to the evidence discussed so far. There are however, some limitations to note in relation to the potential influences impacting the outcomes of this research. As participants were still inpatients and data was collected within the clinical area they were being cared for, this may have implicitly influenced responses as a result of concerns regarding subsequent care. The research does provide preliminary insight into compassion from the individual perspective, providing a platform from which other research can advance understanding. However, as this research is the only empirical study specifically exploring

individual perceptions of compassion in the UK nursing context, the sample size of ten participants provides only an emerging insight.

Throughout the literature discussed so far, there is a clear sense that perceptions of compassion are founded on aspects associated with personality, attributes, relationships, recognition of suffering or vulnerability and individualised approaches to care. This elucidates a range of concepts that may have resonance for other individuals experiencing care, offering some understanding of compassion in nursing. However, there still remains a significant gap in knowledge in the existing evidence base to provide a comprehensive and exclusive understanding of what the individual who has experienced care perceives compassion to involve in the context of nursing in the UK.

2.4.4 Personality and Compassion

A range of evidence identifies the qualities and characteristics of the ideal nurse, all of which clarify compassion to be a vital attributional aspect of the nurse's personality (Price, 1999; Smith and Godfrey, 2002; Crosby *et al.*, 2003; Sivamalai, 2008; Rchaidia, 2009; Catlett and Lovan, 2011; Johnson and Cowin, 2013).

Although this evidence fails to explore what compassion specifically involves, it does highlight the significance of the nurse requiring a personality that has affinity with compassion. The evidence discussed previously in relation to perceptions of compassion also suggests that personality and associated attributional traits are significant to compassion, specifically highlighting sympathy and empathy to be influential antecedents to invoke compassion.

Personality is a complex phenomenon that has been subject to extensive investigation over the past century, with the four major perspectives of psychoanalytical, genetic, humanistic and behaviourist suggested as a means to understand it. These four perspectives present extremely polarising views, and immense theoretical divergence of opinion. Schultz and Schultz (2005) suggest that in the face of such divergence, human personality should be considered in terms of how it evolves in relation to influences such as nature versus nurture, uniqueness versus universality and past versus present. Contemporary theories provide a more holistic understanding of human personality, considering both intrinsic biological influences in terms of how personality is initially shaped, and extrinsic influences in terms of how the social and cultural environment can interact to modify this (McCrae, 2011; Mayer, 2015). This holistic understanding is exemplified in factor models, such as the five factor model (FFM) of personality (McCrae and Costa, 1987, 1997).

The FFM of personality draws its foundations from classic personality trait theory (Allport and Odbert, 1936; Cattell, 1946; Comrey, 1970; Eysenck, 1992). It proffers a taxonomy of traits to represent human personality, which have been validated across a wide range of international cultures and contexts to support its credibility (McCrae and Costa 1987, 1997; Shafer, 1999; Shaohua *et al.*, 2009; John, Naumann and Soto, 2008; Mathews, Deary and Whiteman, 2009). The model proposes that personality is represented by five major factors, which provide higher order labels to subsume an extensive taxonomy of traits, broadly relating to openness, conscientiousness, extraversion, agreeableness and neuroticism (OCEAN)

(Appendix 3). Individuals are thought to lie on a continuum, which extends between the extremes of two polarised points (McCrae and Costa, 1987, 1997). It is this concept which supports the claim that although human traits are universal, differences are expected in the personality that ensues as a result of an individual's unique position on the continuum, due to influences arising from innate factors and experiences in the social world (Goldberg, 1992; McCrae and Costa, 2008; Roberts and Mroczek, 2008; Mathews, Deary and Whiteman, 2009; McCrae, 2011).

Recent evidence to advance factor models of personality identifies that traits such as compassion are underpinned by principles associated with morality, an individual's ability to discern between right and wrong (Oxford University Press, 2010). The H factor of personality claims to represent this, and has been identified as an additional factor to the FFM in the HEXACO model (Honesty-Humility, Emotionality, Extraversion, Agreeableness, Conscientiousness, Openness to Experience). This additional honesty-humility factor highlights the significance of balancing self focused interest with the interests of others, to support pro social and helping behaviours such as those associated with compassion (Ashton and Lee, 2008). Being compassionate is considered to be the fundamental basis of morality, and essential in guiding individuals to engage in benevolent actions (Schopenhauer, 1903; Koocher and Keith-Spiegel, 2008). Hence, compassion is regarded by some commentators as a characteristic human trait that personifies the principle of morality (Cohen and Morse, 2014; Covington, 2015).

Cohen and Morse (2014) suggest that personality traits such as empathy are vital for compassion to ensue. This is apparent in the research of Haas *et al.* (2015), which identifies that individuals who have high affinity with the factor trait of agreeableness have an enhanced predisposition to implement pro social action, due to the ability to see things from another's perspective. This resonates with the work of Lown, Rosen and Marttila (2011) who purport that compassion is dependent on invoking the traits of sympathy and empathy. Baron-Cohen (2012) proposes that an empathy continuum exists, comprising two polar opposite ends. At one end, the individual lacks empathy and may have difficulty forming relationships or recognising the suffering of others. At the other end, the individual has remarkable empathy, and is willing to go out of their way to recognise suffering and help others. Hefferon and Boniwell (2011) identify that positivity is key to promoting human emotional responses such as compassion, considering this to be pivotal in motivating individuals to engage in acts of kindness and pro social interactions. However, individual differences in positivity are known to exist as a result of intrinsic levels of affective style (Davidson, 2003), commensurate with the notion of unique differences in human personality across individuals (McCrae and Costa, 2008).

2.4.5 Vocational Personality and Compassion

Vocational personality theory suggests that individuals can be motivated towards specific careers as a direct result of personality traits (Holland, 1959) and their position within a framework that fits the person to the occupational environment (Chamorro-Premuzic, 2015). The ideology of this approach is regarded as an effective means to facilitate congruence of career choice, determining an individual's fit into an appropriate work environment to facilitate job satisfaction, stability and performance (Nauta, 2010). The Holland Code (1959) offers such a framework and

comprises a taxonomy of personality traits, grouped into the codes of realistic, investigative, artistic, social, enterprising, conventional (RIASEC). Individuals may have affinity with more than one code as a result of their personality traits, and therefore may be suitable for a range of jobs that fall within these codes. Individuals with affinity for the codes of social, realistic, investigative and conventional are thought to be the most suitable for nursing careers (Holland, 1959).

The value based recruitment (VBR) strategies discussed earlier reflect some affinity with vocational personality theory, highlighting that individuals should be actively recruited for specific values to ensure that the most appropriate individuals are selected for nursing positions (HEE, 2014 a). The VBR strategy is founded on the values of the NHS Constitution (DH, 2010 a), and clearly identifies a wide range of personality traits that may be elicited through selection processes. The work of Gottfredson (2005) builds upon vocational personality theory further, proposing that factors of circumscription and compromise also guide career choices, rather than individual personality alone. Gottfredson claims that individuals are drawn to particular careers as a result of a complex interaction between self-concept of their attributes, available opportunities arising from socioeconomic constraints and perceptions about individual ability and what a job actually entails. This often involves individuals making compromises to maintain perceived levels of circumscribed social and gender status.

A range of evidence suggests that individuals are driven to nursing careers as a result of an intrinsic desire to care for others, influenced by pro social traits such as

altruism and empathy (Ditommaso *et al.*, 2003; Maben, Latter and Clark, 2007; Baughan and Smith, 2008; Newton *et al.*, 2009; Eley, Eley and Rogers-Clark, 2010; Baldacchino and Galea, 2012 a, b; Penprase *et al.*, 2013; Wood, 2014). In terms of the factor models of personality previously discussed, altruism is identified as a trait associated with agreeableness, conscientiousness and honesty-humility and therefore, regarded as an integral component of compassion (McCrae and Costa, 1987, 1997; Ashton and Lee, 2008; Williams, Dean and Williams, 2009). However, there is emerging evidence to suggest that individuals are increasingly less likely to cite altruism as a motivating factor to embark upon a nursing career, instead citing aptitude, job security and salary (Miers, Rickaby and Pollard, 2007; Johnson, Haigh and Yates-Bolton, 2007; Cho, Jung and Jang, 2010).

2.4.6 Learning About Compassion in the Early Years

Knowledge, behaviour and attitudes can be significantly influenced by experiences encountered in childhood as a consequence of social and environmental factors (Pervin and Cervone, 2010; Price-Mitchell, 2013). Although human personality traits are universal, individual differences can be influenced in response to exposure to these factors (McCrae, 2011), reflecting the notion that nature and nurture serve to complement one another, rather than compete against one another (Chamorro-Premuzic, 2015; Buss, 2008). Social and environmental factors have been demonstrated to influence issues such as instilling fear (Watson and Rayner, 1920), promoting racial prejudices (Cacioppo, 1999 cited in Pervin and Cervone, 2010) and affecting levels of self-esteem (Baccus, Baldwin and Packer, 2004) supporting the argument that personality, attitudes and behaviours can be shaped through experiences in childhood.

It is claimed that such conditioned responses involve a physiological change in the brain, affecting the connections between the neurons associated with memory (Kandel, 2006). This suggests that exposure to particular behaviours can contribute to learned changes in personality, reinforcing the notion that social and environmental influences can be immensely important in the development of personality. In terms of compassion, this suggests that exposure to positive experiences of compassion can be instrumental in developing it as an integral part of individual personality. Price-Mitchell (2013) claims that children and teenagers require exposure to life experiences that instil an intrinsic moral compass, from which their subsequent personality, attitudes and behaviours emerge.

Research to investigate pro social behaviour in children demonstrates that engaging in acts of compassion is essential for children to develop the skills to recognise the needs of others, respond with compassionate behaviours and influence their perceptions of this as the social norm (Sanders, 2010; Layous *et al.*, 2012). Ongoing exposure to, and involvement with, such experiences is essential to advance moral principles and associated levels of compassion in children (Johansson, 2008).

Strategies to cultivate compassion across society are advocated (Greenberg and Turksma, 2015), with early years education being adopted in the United States of America (USA) as a catalyst to instil compassionate values (Wolpow *et al.*, 2011; Hollingshead *et al.*, 2009) and increasingly attracting interest within the UK (Peterson *et al.*, 2014). Within the Charter for Compassion discussed earlier (Armstrong, 2011) it is claimed that embedding compassion in everyday life is

dependent on young people learning about it from others, as an integral part of educational curricula which aim to promote and develop moral values.

The notion that experiences in childhood can influence behaviour in adulthood, is demonstrated in a longitudinal study which identifies positive correlations between pro social behaviour in childhood and later adult life (Richards and Huppert, 2011). This suggests that learning about, and engaging with, compassionate acts in the early years, is essential to instil such moral behaviours in adulthood. This can therefore become the social norm and as such, equip individuals with the fundamental building blocks to facilitate compassion in adulthood (Price-Mitchell, 2015).

2.4.7 Learning About Compassion in the Formal Nurse Education Context

As discussed earlier, in the context of professional nursing there is an ongoing requirement for nurses to demonstrate and practice with compassion throughout the entire career trajectory (NMC, 2004; NMC, 2010; NMC, 2015 a, b). Educational strategies are considered to be the most formal method to disseminate and perpetuate societal values such as compassion (Dimitriadou, Pizirtzidou and Lavdaniti, 2013). In the nurse education arena, there is ongoing debate regarding whether compassion is wholly innate, or if there is scope to provide educational strategies to teach it (Richardson, Percy and Hughes, 2015; Sinclair *et al.*, 2016 b). This debate has been further heightened by the move to an all graduate profession, fuelling suggestions that nurses who are exposed to higher levels of education are less able, or less willing, to practice with compassion (Deaton *et al.*, 2014). Despite this dichotomy, there is emerging evidence that graduate nurses can improve outcomes (Aiken *et al.*, 2014) and that formal education can be instrumental in teaching nurses to care with compassion (Bray *et al.*, 2014). However, it is acknowledged this may be dependent

on the initial baseline level of compassion that individuals possess at the outset of the career trajectory (Woodbine and Taylor, 2006; Bramley and Matiti, 2014; Richardson, Percy and Hughes, 2015).

Research to explore the impact of a post registration university based module in human caring, identified that nurses experienced an enhanced understanding of caring related concepts. Consequently, nurses were enabled to develop enhanced connections with others, clarify their own personal values and draw upon this to engage in holistic caring interventions to enhance their nursing practice (Hoover, 2002). In a systematic analysis to identify if the human attribute of empathy could be taught in pre and post registration nurse education, it was established that nurses who were exposed to empathy education developed an enhanced understanding of the concept. Empathy education was primarily delivered through formal classroom based strategies, focusing on role play, problem based case scenarios and experiential learning in a simulated environment, supporting nurses to see things from the other's perspective (Brunero, Lamont and Coates, 2010).

A research project across more than one hundred nursing units in the USA to investigate the impact of formal education on concepts of human caring supports the notion that compassion can be taught. Herbst, Swengros and Kinney (2010) identified that education was an effective strategy to enhance affective attributes such as compassion, and was instrumental in positively affecting the nurse's caring behaviours in the clinical context. Dewar and Mackay (2010) support the assumption that compassion can be taught, identifying that educational and collaborative

teaching strategies can provide a means to enhance compassion. Tunner (2015) concurs that compassion can be taught by development strategies which promote kindness and support implementation of the philosophy of the Golden Rule (Armstrong, 2011). This identifies that nurse educators in the formal educational environment may be the primary role models to teach and demonstrate compassion (Mackey, Goddard and Warner, 2007), through educational strategies which promote compassionate behaviours (HEE, 2015).

As previously discussed, the notion that personality traits are universal, relatively enduring and inherently intrinsic, is a concept that is regarded as credible (Allport, 1936; Eysenck, 1992; McCrae and Costa, 1987, 1997). However, the view that personality traits remain inflexible across an individual's life span is disputed by a range of emerging evidence. Roberts and Mroczek (2008) highlight that personality traits have the potential to change across the life span, identifying personality factors that are associated with compassion (agreeableness and conscientiousness) to be highly predisposed to this. Personality traits can be subject to development in the twenty-to-forty, and over-sixty age groups (Srivasta *et al.*, 2003; Roberts, Walton and Viechtbauer, 2006), refuting the argument that traits developed through childhood are resistant to change. Personality trait changes can occur in response to specific life experiences and events that an individual may encounter over their life trajectory (Roberts, Wood and Smith, 2005; Roberts and Mroczek, 2008). These changes ensue through a process of characteristic adaptation, whereby personality is shaped by the external phenomena that an individual is exposed to in the social world (McCrae *et al.*, 2000; McCrae, 2011).

McAdams and Pals (2006) identify that dispositional and characteristic adaptations develop as a result of life narratives, which arise from exposure to social and environmental factors. The work of Wear and Zarconi (2008) highlights the complex interplay of nature and nurture, suggesting that early years foundational, pre-clinical and intra-clinical educational strategies were vital to develop compassion in medical students. This suggests that education may also be a valid means to foster compassion in nursing through approaches which support the nurse's ability to appreciate the individual perspective (Mead, 1934; Simpson, 2006; Price, 2013; Adamson and Dewar, 2014; Tevendale and Armstrong, 2015; Kenny, 2016; Sinclair *et al.*, 2016 a, b; Smith *et al.*, 2016).

2.4.8 Learning About Compassion in the Care Context

Professional socialisation into nursing is a vital process to support the novice nurse to internalise the values, norms and behaviours of the profession, and accept them as an integral part of their professional nursing identity (Du Toit, 1995; Gregg and Magilvy, 2001; MacKintosh, 2006; Griffiths *et al.*, 2012). Socialisation in the care context is primarily influenced by nurse mentors, who have responsibility for coaching, facilitation, role modelling, assessment and supervision of the novice nurse (NMC, 2008 a; Badger, 2013). Mentoring supports advancement of the novice nurse in terms of their acquisition of knowledge and skills, enhancing theory-practice links and developing professional identity (Casey and Clark, 2011). However, this multi-faceted and complex role can pose challenges, with some nurses reporting that they felt unprepared to implement the role effectively and as such, required appropriate education to support them (Mead, Hopkins and Wilson, 2011).

Role modelling is regarded as instrumental in the process of professional socialisation, and reflected in the exemplary nurse who demonstrates positive characteristics which are worthy of imitation (Holton, 2004; Darling, 1984 cited in Pellat, 2006; Perry, 2009 b). Role modelling is founded on social learning theory, which proffers that much of an individual's learning occurs through their observations of others. It is dependent on an individual demonstrating a pattern of behaviour, which others attend, retain and reproduce (Bandura, Ross and Ross, 1961; Bandura, 1977). Individual motivation to reproduce a particular behaviour is central to this, leading to reinforcement or inhibition. However, it is also dependent on an individual's level of competence, highlighting the potential for the novice nurse to simply imitate the behaviours they may observe or be exposed to (Bandura, 1977), in order to fit in to the culture of the care context (Charters, 2000; Malouf and West, 2010).

Exemplary role models are an important catalyst to transform the professional development of the novice nurse by teaching, guiding and demonstrating appropriate nursing behaviours in the care context (Bartz, 2007). However, there is evidence to refute the notion that all nurses demonstrate the characteristics of good role models (Alain, 1989; Vallant and Neville, 2006; Levett-Jones and Lathlean, 2009; Houghton, 2014; Zarshenas *et al.*, 2014). This can ensue in the perpetuation of observed negative behaviours, as novice nurses strive to assimilate to the context of professional nursing care, the most influential environment for appropriate role modelling to occur (Brown, Stevens and Kermode, 2012; Dimitriadou, Pizirtzidou and Lavdaniti, 2013; Houghton, 2014; Goodare, 2015). Acknowledging this

highlights the importance of positive role modelling and the significance of supporting the development and sense of belongingness that novice nurses require in the care context (Vinales, 2015).

In a study to compare attitudes at the beginning and end of a nurse education programme, students were noted to have decreased affinity with the notion that nurses were kind and compassionate. Conclusions were drawn from this to suggest that professional socialisation had negatively influenced perceptions, due to the cultural context and behaviours that students had been exposed to (Bolan and Grainger, 2009). In a longitudinal study to compare the attitudes of student nurses at the end of their programme with their attitudes at one-year post qualification, significant differences were noted in relation to ideals, values and aspirations, with some nurses compromising, and others forsaking, their ideals. This was reported to have arisen as a consequence of socialisation experiences in challenging care contexts, where covert rules dominated the underlying philosophy of care (Maben, Latter and Clark, 2007). Although there is evidence to support the fact that human caring behaviours and empathy can be taught in the formal education context, it is clear that sustaining this is dependent on the subsequent experiences that individuals are exposed to in the care context (Hoover, 2002; Brunero, Lamont and Coates, 2010). It is therefore vital that the practice context of care cultivates a culture where novice nurses are inspired to implement nursing care with compassion (HEE, 2015).

2.4.9 Learning About Compassion Through Reciprocity

The notion of reciprocity is key to supporting nurses to learn about compassion (Valant and Neville, 2006). Reciprocity is a social rule that involves a mutual exchange, whereby individuals interact with one another and in return, reciprocate

the kind of treatment that they have received themselves. Reciprocal interactions can develop relationships, perpetuate social norms and encourage imitation by others (Regan, 1971; Bandura, 1977; Cialdini, 2006), supporting the assumption that behaviours can be shaped by social and environmental factors (Mead, 1943; Blumer, 1969; Baccus, Baldwin and Packer, 2004; Cacioppo, 1999 cited in Pervin and Cervone, 2010). In situations where individuals experience negative encounters, this can ensue in negative reciprocity whereby the individual responds with an action that has an equally similar negative effect (Caliendo, Fossen and Kritikos, 2012).

Reciprocal altruism, is a mutual interaction that engenders co-operation between individuals, and suggests that helping another individual in some way, inevitably involves some cost to the helping individual (Trivers, 1971). In order for reciprocal altruism to flourish, behaviour cannot be founded on self-focused motivations or the expectation of any degree of benefit for the helping individual. Rather, it must be founded on an unselfish desire to help others (Stephens, 1996). The work of Titmuss (1997) demonstrated the power of altruism in relation to individuals donating blood, without expectation of anything in return. Blood donation practice in the USA, where the activity had been commercialised by financial reward, was compared with practice in the UK, where the activity was founded on reciprocal altruism (Rapport and Maggs, 2002). The UK approach was considered to be more effective, morally acceptable and fundamentally underpinned by human values, thus negating tensions between economic and social value norms (Koplin, 2015).

The role of social value norms can have an immense impact on reciprocity. In societies which assume a more collective identity, there is an inherent social responsibility to help others without any expectation of reciprocation, whilst in individualist societies, social responsibility norms are often applied selectively (Hedge and Yousif, 1992). The actions of individuals can therefore be influenced by perceptions that the person requiring help has created their own situation through personal choice and therefore, deserves to be in that situation (Myers, 1996). This can subsequently impact engagement in reciprocal altruism, and lead to an individual refraining from selflessly giving something of themselves to help another.

The notion of individuals being worthy of compassion is highlighted in the work of Simpson, Clegg and Pitsis (2014), who purport that decisions about implementing compassion are underpinned by an internal cognitive assessment to determine if the individual in need is a legitimate, or illegitimate receiver for compassion. This suggests that individuals may be influenced somewhat, about engaging in acts of reciprocity, reciprocal altruism or compassion. This may be based on their assumptions, perceptions or judgements, and influenced by behaviours they have been exposed to in the context of care.

Reciprocity has been demonstrated to operate more effectively in smaller communities where individuals exhibit higher levels of co-operative and caring behaviours (Steblay, 1987). This suggests that tensions may exist in the context of large caring environments, whereby collectivist approaches and values can be diluted (Ritzer, 2004). However, reciprocity is considered to be a behaviour that can be

enhanced in larger communities through appropriate learning and socialisation strategies. Dawkins (1976) suggests that altruistic virtues are attributes that can, and should, be taught in a society that aspires to promote human morality, because humans are intrinsically selfish as a result of an evolutionary and innate desire for self-preservation. This suggests that appropriate education across the life span is essential if individuals are expected to learn, develop and implement compassion as the norm.

2.4.10 Organisational Culture and Compassion

Politically driven developments in society over past decades have created what has been termed a ‘McDonaldisation’ effect, resulting in practices that are highly structured and governed by strategies to achieve efficiency, calculability, predictability and control (Ritzer, 2004). Such political developments have been extended to the nursing arena, driving quality and introducing strategies to measure outcomes (DH, 2002 b; DH, 2008; NHS England, 2015 a, b). As a result, the potential to inadvertently move the focus of care away from the person has emerged, in favour of achieving targets and quality indicators, which strive to produce a standardised vision of organisational identity (Bradshaw, 2009; Timmons and East, 2011). Sturgeon (2010, p1050) terms this ‘McNursing’, whereby market driven forces and bureaucracy often focus on measurable outcomes such as infection control statistics or waiting times, rather than the individual experience of care.

The ‘McDonaldisation’ of nursing, and indeed wider society, is a potential catalyst to influence the behaviours of nurses and the individuals they are caring for. This arises from politicised systems and processes, which can diminish compassion through mechanistic approaches that are underpinned by a desire for speed and efficiency

(Mottram, 2011), potentially invoking individualist, rather than collectivist philosophies of care (Thake, 2008). It is claimed that emerging tensions between the art and science of nursing can impact this further, as a result of strategies which consider that compassion can be objectively measured, rather than recognised as an intrinsic attributional virtue (Bradshaw, 2009; Smajdor, 2013).

Political influences to structure reforms in the nursing care arena and achieve a more standardised organisational identity have inevitably influenced the culture of the care context, impacting individual performance and outcomes (Hunt *et al.*, 2012; Smajdor, 2013). Durdy (2014) purports that ongoing organisational change, particularly in the face of austerity, has compounded this further, affecting both staff and patients at a negative level. Staff morale has declined, leading to the potential for reduced productivity and declining standards of fundamental care, as nurses have assimilated to new ways of working within an organisational context that may not always be perceived as supportive or enabling (Salauroo and Burnes, 1998; Gulliver, Towell and Peck, 2003; Arnetz and Blomkvist, 2007). Organisational change has impacted the individual experience of care, due to forces creating tension between nursing values and marketisation (Drummond-Hay and Bamford, 2009; Hunter and Williams, 2012). Subsequently, the culture of care has been impacted, as a result of challenges to practice such as workload and declining resources. In turn, this has influenced nurse's perceptions of feeling devalued and created an ensuing sense of powerlessness to implement change (Williams, Perillo and Brown, 2015).

Organisational culture is exemplified by socially constructed collective values and practices, which are shared with others and perpetuated through patterns of behaviour (Daft, 2007; Hunt *et al.*, 2012). Schein (1985) purports that organisational culture is complex and multi-dimensional, involving three levels of ascending importance relating to artefacts, beliefs and values and assumptions. Artefacts are the visible aspects of culture which manifest in observable behaviours that are governed by routine and ritual practice. Beliefs and values underpin these observable behaviours and provide the justification for the practice that ensues. Assumptions form the basis of these unconscious shared beliefs and values, and are reflected in the behaviours that are demonstrated through a prevailing hidden agenda. This hidden agenda can impact compassion through the operation of covert rules, ensuing in nurses exhibiting emotional detachment, rather than emotional attachment, in order to cope with the challenges of contemporary practice and assimilate into the established culture of care (Smith and Kleinman, 1989; Maben, Latter and Clark, 2007).

2.4.11 Staffing Levels and Compassion

Nursing has been impacted by decreasing staffing levels which have increased workloads, inevitably influencing the individual's experience of care. The RCN (2010 b) highlight that the skill mix ratio of Registered Nurses and support workers in the NHS decreased from 65% in 2005, to under 60% in 2010. However, the UK contingent of the global RN4CAST study suggests that this skill mix ratio has, in fact, been noted to be as low as 43% in some care contexts (Ball *et al.*, 2012). In an employment survey, nurses reported ongoing decreases in staffing levels, with 55% reporting reductions in Registered Nurse numbers and 35% reporting reductions in support worker numbers (RCN, 2013). In fact, HEE (2015) identified that in 2014,

support workers were responsible for 60% of the direct nursing care interventions delivered to individuals experiencing care within the NHS. In the private sector, similar staff reductions have been reported, creating unmanageably high workloads which can impact on care delivery (RCN, 2010 b; Unison, 2013). This raises serious concerns for the nursing profession as staffing levels are undoubtedly of importance. This was apparent in the Mid Staffordshire NHS Foundation Trust Inquiry, discussed earlier to illustrate negative experiences of compassion, where staffing levels were noted to be dangerously low due to an organisational establishment which required a further 120 nurses to operate safely (Moore and Waters, 2012).

A clear correlation between low Registered Nurse staffing levels and adverse outcomes has been demonstrated across a range of international research, identifying links which associate capacity to maintain patient surveillance with a lack of time arising from low staffing levels and high workloads (Aiken *et al.*, 2002; Needleman *et al.*, 2002; Lang *et al.*, 2004; Rafferty *et al.*, 2007; Cho and Yun, 2009; West *et al.*, 2009; Duffield *et al.*, 2011; Aiken *et al.*, 2014; West *et al.*, 2014). There is also a range of evidence that highlights incidences of missed care across a variety of NHS and private care contexts, where nurses have failed to meet the most fundamental of individual needs (Cho and Yun, 2009; Duffield *et al.*, 2011; Unison, 2013). The RCN (2012 a) identify that there is a link between Registered Nurse levels and a lack of time to attend to all the required care needs of the older individual, resulting in 'care left undone'. This is corroborated through a survey of almost 8000 Registered Nurses, where respondents identified that they were aware of failing to attend to fundamental needs due to a plethora of competing priorities (RCN, 2011). To

address such challenges, the USA have introduced mandatory Registered Nurse ratios (Theodore *et al.*, 2010; Tevington, 2011), but despite support for such a strategy in the acute sector of the NHS (RCN, 2010; RCN 2012 a; NICE, 2014), to date this has not been mandated at government level.

The issue of ‘care left undone’ impacts across a wide range of NHS services, and affects individuals from a variety of age groups. In a survey of almost 3000 Registered Nurses working in medical and surgical environments across 46 NHS hospitals, 86% reported one or more fundamental care activity left undone during their last working shift, exemplified by failures to provide comfort to those in distress. The findings suggested that the focus of care was often on completing high priority clinical skills or technical activities due to time pressures, preventing engagement with the individual (Ball *et al.*, 2013). Similar incidences have also been demonstrated in the private care context, where time pressures have led to a focus on technical tasks, resulting in missed opportunities to attend to the most fundamental of care needs (Lupton and Croft-White, 2013; Unison, 2013).

These findings are significant, given the evidence which highlights that in care contexts with higher skill mixes of Registered Nurses, particularly degree level graduates, less episodes of missed care and improved outcomes are reported than in those with lower skill mixes (Kalisch, 2005; Kingma, 2009; Kalisch, Landstrom and Williams, 2009; Kalisch, Tschannen and Lee, 2011; Ball *et al.*, 2013; Aiken *et al.*, 2014). This evidence identifies challenges for nurses in relation to balancing the need to undertake clinical skills, meet organisational priorities and ensure that care is

delivered with compassion. This notion is supported in a survey, which identified that 76% of Registered Nurses reported that they felt unable ‘to get the job done’ due to inadequate staffing levels, despite 94% reporting that high standards were expected from managers in the care context (Ball *et al.*, 2012).

2.4.12 Capacity for Compassion

Nurses are increasingly under pressure to manage both the art and science of nursing, however 56% of Registered Nurses who participated in an employment survey indicated that too much of their time was taken up engaging in non-clinical activities (RCN, 2013). In a survey of more than 8000 community and district nurses in the UK, participants identified that 19% of their time was spent on administrative duties, whilst only 37% of time was spent on direct care provision (Ball *et al.*, 2014). Similar figures have been replicated in international research (Hendrich *et al.*, 2008; Westbrook *et al.*, 2011), and further compounded by the advancing use of technology for electronic records (Donohoe, 2011). As a result, many nurses perceive that time for compassion is significantly diminished (Spinks, 2013), as a result of the need to manage multiple care activities simultaneously (Smajdor, 2013). However, the argument that time may be an influencing factor is refuted by evidence which suggests that compassion merely requires minimal expenditure of time or effort, as it is claimed that it can be demonstrated through small acts of kindness (Fogarty *et al.*, 1999; Perry, 2009 a; Lewis, 2012; Reimer, 2013; Bramley and Matiti, 2014; Reimer, 2015; Scammell, 2015).

In the last century, it has been reported that documentation is an activity that takes up too much time and prevents engagement with people (Busche, 1928 cited in Stokowski, 2013, p1). This issue seems to have changed very little, with nurses

reporting that it has been exacerbated by increasing requirements to utilise electronic systems. In a survey of 7000 nurses using electronic documentation in the USA, many reported spending increasing amounts of time to utilise the system, detracting their focus away from caring for the person. Nurses reported that they perceived documentation to be an aspect of practice on which they would be judged more vehemently than the actual care they delivered, resulting in the sense that they were required to focus on the chart, rather than focus on the person they were caring for (Stokowski, 2013). Many nurses using electronic systems have suggested that up to 60% of their time is spent engaging with documentation (Cornell, Riordan and Herrin-Griffith, 2010). However, a cross sectional analysis estimated that regardless of whether documentation was paper based or electronic, nurses spent approximately 19% of their time on the activity (Yee *et al.*, 2012).

In the UK, research has suggested that nurses actually only spend between 35% and 46% of their time directly with the person they are caring for, with the remaining time being taken up by indirect care activities and non-nursing tasks (Hurst, 2010). Wright and McSherry (2013) conducted an observational analysis to investigate how nurses spent their time, identifying that during a nine-hour span of duty, nurses only provided direct care for a total of two hours and twenty-five minutes, accounting for less than 30% of their working day. This was mirrored in the work of Ball *et al.* (2014), who highlighted that only 37% of community nursing time was spent on direct care activities. It is suggested that due to time pressures and competing workload requirements, nurses are required to constantly prioritise care activities using a stacked approach, often resulting in clinical and technical interventions

taking precedence over interacting with the individual experiencing care (Patterson, Ebright and Saleem, 2011).

Technological advances related to the use of medical equipment to support nursing care practice is reported to impact on compassion further. Lomas and West (2009) identified that although 85% of nurses reported using electronic devices to record observations, 42% believed that this did not enhance recognition of deterioration. In fact, Ansell, Meyer and Thompson (2015) found that using electronic equipment inhibited observational skills, as the focus of care was on managing the device, rather than attending to the person. The reconcilability of technology and compassion is emerging as a contemporary debate in nursing, particularly in care contexts where it is assigned disproportionate importance to the detriment of interpersonal interaction (Boston and Bruce, 2015). In a research study conducted in Norway, it was identified that the use of technology had a negative impact on the interactions that ensued between student nurses and the individuals they were caring for (Jordal, Heggen and Solbraekke, 2015). This suggests that technology may exert a level of influence on compassion, with commentators suggesting that strategies need to be implemented to position technology as an activity which adds value, rather than diminishes it (Noh, Arthur and Sohong, 2002; Dewar, 2013; NHS England, 2016).

2.4.13 Recognising Opportunities for Compassion

The care context has potential to impact on the nurse's ability to notice individual distress, or identify opportunities to demonstrate compassion, due to 'inattentional blindness' (Paley, 2014, p278). 'Inattentional blindness' refers to the potential for individual failures in observing, attending and noticing events due to attentional

capacity being invested in another activity (Mack and Rock, 2000). This concept is illustrated in the invisible gorilla experiment, where only half the participants noticed a man dressed as a gorilla in a basketball video, as their attention was focused on a prescribed activity of counting ball passes between players (Simons and Chabris, 1999). The work of Darley and Batson (1973) to investigate pro social and helping behaviour in priests, also identified that having adequate time was an influential factor impacting an individual's capacity, or choice, to notice another's need or distress. Recognising the needs of others is said to elicit the arousal of personal distress, subsequently invoking an empathetic response within a cost-reward or empathy-altruism model (Dovidio *et al.*, 1991; Batson, 1987). Arousal to distress initiates a biological response, invoking pro social behaviours through 'The Human Oxytocin Mediated Empathy' response (Zak, 2011). This response is reportedly susceptible to influence by cortisol, a hormone associated with stress, which in turn diminishes levels of oxytocin. As a result, humans are thought to operate within a rational-rationality model, whereby they are predisposed to implement action that is often merely adequate, particularly in situations when cognitive resources are pressured due to other activities (Zak, 2011).

Paley (2014) supports the person-situation argument, suggesting that what has been labelled as a 'compassion deficit' in nursing is not a product of individuals being uncompassionate *per se*. Rather, it is a product of the contexts and situations which nurses find themselves functioning within, arising from political influences which have impacted traditional ways of working and shaped nurse's behaviours, rather than their aspirational values. However, others consider this position to be

misleading and overly simplistic, citing factors such as personality, motivation and learned experiences, in addition to the environment, with significant potential to influence compassion (Darbyshire, 2014; Rolfe and Gardner, 2014).

2.4.14 Leadership and Compassion

Leading for compassion involves striving to ensure that others feel cared about, by leaders who treat their staff as human and regard them as partners in a reciprocal working relationship (Cooper, 2013). This requires leaders to engage with nurses to understand the complexity of the role, appreciate the emotional labour involved when caring for others and subsequently identify resolutions to embed compassion as a fundamental aspect of nursing practice (Hornett, 2012). Positive and enduring leaders are primarily characterised by the attribute of compassion, supporting them to care about their staff and the wider group they are responsible for. This facilitates compassionate leadership, which involves vision, sharing the vision and inviting others to spread the vision (Briner and Pritchard, 1997). It relies on a partnership approach, whereby leaders in the care context are empowered by the organisation to disseminate a vision for compassion. This can motivate other nurses to reproduce the vision, thus perpetuating compassion in nursing (Brown, 2013). Leadership development is the catalyst for this (Dewar and Cook, 2014), supporting the dissemination of exemplary approaches across the organisation through strategies to share best practice with others (Edinburgh Napier University and NHS Lothian, 2012).

Principles of leadership are not ethereal entities steeped in mystery and only attainable for the minority. Rather, they are subject to educational influences and therefore potentially attainable by the majority (Posner and Kouzes, 1997). A study

of leadership development in adolescents, identified that education was an important strategy to develop leadership attributes and behaviours. This facilitated progression from needs based leadership, whereby leaders focused on meeting their own needs, to compassionate leadership, whereby they focused on meeting the needs of others. The need to develop effective reflective skills is considered essential to this progression, through a process of transformation for leadership (Martinek, Schilling and Hellison, 2006). The transformational leader is a role model who is motivated to develop the leadership ability of the wider team, inspiring practice that is founded on shared values and aspirations. High affinity with factors of personality, such as agreeableness, extraversion and openness is exhibited, and an active choice to lead is made (Yoder-Wise, 2007; Chamorro-Premuzic, 2015).

Morality, in the sense of being committed to and socially responsible for the right action, is central to the attributes required of leaders (Bjarnason and LaSala, 2011). It is a fundamental aspect of transformational strategies which can be exhibited through authentic or servant leadership (Stone, Russell and Patterson, 2004; Eagley, 2005). Authentic leaders remain true to their own sense of self, and act in accordance with this, promoting personally internalised principles, within a relationship with their staff which is underpinned by transparency, openness and trust, and which seeks to achieve shared goals and objectives (Gardner *et al.*, 2005). Servant leaders build upon this approach, working to focus more effectively on the needs of their staff, rather than simply focusing on meeting the objectives of the organisation (Stone, Russell and Patterson, 2004). The personal attributes, values and moral principles that such leaders possess are instrumental in shaping the actions that

ensue, within the environments in which they lead (Boddoes-Jones and Swailes, 2015). However, it is acknowledged that not all individuals located in formal leadership positions are effectively equipped with the appropriate attributes for effective and compassionate leadership (Marshall, 2011). This resonates with the principles of factor models of personality discussed earlier, which identify that attributional differences exist amongst individuals.

The reality of leading requires individuals to combine the conventional aspects of management with those of effective leadership. This involves balancing business acumen with benevolent action, promoting compassion for staff and facilitating compassion for individuals experiencing care (Millward and Bryan, 2005; Cropper, 2009). In a study of teachers in Israel, it was apparent that teachers exhibited increased levels of motivation, enthusiasm and overall job satisfaction when they experienced compassionate focused leadership. In situations where teachers were faced with managing challenging student issues, the effects of such leadership equipped them with the ability to maintain their goals, aspirations and skills to overcome burnout (Eldor and Shoshani, 2016). This indicated that compassionate leadership could be a positive strategy to enhance staff well-being and therefore, promote positive outcomes for others. Similar findings are evident in a study to investigate the effects of compassionate leadership on 284 nurse's anxiety, burnout and intention to quit the profession (Choi *et al.*, 2016). When nurses experienced compassion from nurse leaders, they were more likely to develop enhanced levels of self-esteem, self-efficacy and self-regulation. This alleviated negative emotions and reduced intention to quit, through supportive and compassionate leadership strategies

which enabled nurses to sustain compassion in their practice, in spite of the challenges they may be facing.

In circumstances where nurse leaders are ill equipped to facilitate compassionate focused leadership, there is potential for negative impacts to emerge. When leaders exhibit a transactional style, it is less likely that they will cultivate an environment which promotes compassion (McDaniel and Wolfe, 1992). Transactional leadership disempowers staff, fails to facilitate team working or inclusive decision making and has the potential to result in devastating consequences to organisation (Wedderburn Tate, 1999; Yoder-Wise, 2007). Ultimately, effective leadership needs to emanate from all levels of staff in order to promote alignment with the shared values and philosophies of nursing. This supports the implementation of nursing care that is not only high quality in clinical terms, but also high quality in compassionate terms, thus adding value by embedding values and behaviours to improve outcomes and experiences (NHS England, 2016).

2.4.15 Morale and Compassion

In an employment survey, 65% of nursing staff working across a range of care contexts reported that they were considering leaving the profession, citing pay and conditions, feeling undervalued by managers and being overwhelmed with workload as the main contributory factors (Unison, 2015). Feelings of being unsupported, undervalued and overworked have seemingly impacted the morale of many nurses, with significant numbers reporting that they are considering leaving the profession, as they feel unable to provide the level of care to which they aspire (RCN, 2015 b). Low morale is potentially leading to compassion being regarded as an aspirational aspect of nursing, rather than a reflection of the everyday reality of practice (Burdett

Trust for Nursing, 2006). This suggests a link to compassion fatigue, a concept that has gained increasing attention over recent years.

Compassion fatigue arises as a unique form of burnout in response to the stresses of caring, contributing to nurses developing symptoms of forgetfulness, decreased levels of attention and professional exhaustion (Joinson, 1992). Compassion fatigue has been explored mainly at a micro level, whereby it is claimed that it occurs as a result of individual personality, resilience and coping strategies. However, there is emerging evidence to suggest that compassion fatigue should also be explored at a macro level, to consider contextual factors as potential contributory influences (Austin *et al.*, 2009; Yu, Jiang and Shen, 2016). Ledoux (2015) purports that compassion fatigue does not simply arise as an inevitable cost to caring, rather it can arise as a result of obstructions to caring. The evidence from Unison (2015) and the RCN (2015 b) suggests that this may well be the case. It indicates that the morale of many nurses is diminishing in response to factors which may be impacting on their ability and aspiration to care with compassion, rather than the emotional labour of caring per se. This can lead to dissonance between professional ideals and practice realities (Curtis, Horton and Smith, 2012), whereby the ongoing challenges of the care context can affect the individual on an emotional level and ensue in a sense of powerlessness to implement the compassionate practices with which they aspire (Smajdor, 2013).

There is emerging evidence to suggest that the challenges of compassion fatigue can be addressed through structured facilitated educational strategies. In a study in the

USA, a formal programme to deliver compassion fatigue resiliency education was evaluated (Potter, Pion and Gentry, 2015). The programme facilitated the nurse's engagement with self-regulatory and self-care activities to manage stress, promoted cultivation of support networks in the workplace and encouraged maintenance of personal focus to achieve aspirational professional values. Following completion of the programme, analysis of the reflective narratives of fifteen nurses uncovered significant outcomes. These outcomes included improved emotional wellbeing and ability to manage stress, in addition to an enhanced reconnection with personal and professional values to sustain compassionate practice. The study recognised that these positive outcomes were instrumental in developing resilience to manage the emotional challenges of nursing, thus improving the overall morale of nurses. Similar studies on the efficacy of compassion fatigue resilience education support these outcomes, further highlighting the utility of facilitated approaches to address diminishing morale in nursing and foster compassion in the care context (Potter *et al.*, 2010; Flarity, Gentry and Mesnikoff, 2013).

2.4.16 Individualised, Person and Relationship Focused Approaches to Compassion

The earlier discussion relating to perceptions of compassion suggested that individualised, person centred and relationship focused approaches were integral aspects of compassion. Assuming an approach which individualises the person and positions them at the centre of care is important, and dependent on the development of effective human relationships (Todres, Galvin and Dahlberg, 2007). Approaches to care which seek to achieve this, focus on recognising the individual as 'subject' rather than 'object' (Binfa *et al.*, 2013, p1151), supporting identification of their individual human needs (Maslow, 1943; Viera de Almeida and Chaves, 2013).

Recognising and respecting individual human needs is imperative to facilitate individualised approaches to nursing care (Coscrato and Bueno, 2015). This is dependent on the nurse sustaining the personal values with which they hold affinity and translating these into nursing practices which can support an individual experiencing care, to feel more human (Todres, Galvin and Holloway, 2009). Individualised approaches to care are fundamentally based on making connections with others to engender a shared level of human understanding (Scammel, 2015), a concept identified to be important in the earlier discussion. This involves attending to what matters to the individual, in order to nurture relationships that are founded on trust. When this fails to occur, practice can be influenced by infra-humanisation, whereby the in group (nurses) may attribute lesser humanity to the out group (individuals experiencing care) (Demoulin *et al.*, 2004; Renger *et al.*, 2016). This has resonance with the concept discussed earlier, that nurses may perceive individuals to be legitimate or illegitimate receivers for compassion (Simpson, Clegg and Pitsis, 2014).

Individualised approaches underpin the philosophy of person centred care, which focuses on what is important to the individual (Hemmingway, Scammel and Heaslip, 2012). Person centred care is complex and dependent on the attributes of the nurse, the care context and the implementation of approaches which facilitate positive outcomes for individuals who are experiencing care (McCormack and McCance, 2006, 2010). Kitwood (1997) argues that person centred care can be denied to some individuals, due to practices which infantilise and objectify them, thus leading to depersonalisation. In order to overcome this, nurses need to focus on implementing

practices which enable connections, develop relationships, foster partnership working, acknowledge individuality, promote agency and implement effective communication strategies (Brooker, 2007). This highlights the importance of personal attributes and relationships as vital aspects of facilitating person centred care, and is supported in the findings of a study to explore what nurses themselves understood about the concept of person centred care (Ross, Tod and Clarke, 2014).

Relationship centred approaches to care rely on person centred approaches to care, and are underpinned by interactions that occur between agents. This requires nurses to acknowledge the perspective of the individual experiencing care, develop and maintain meaningful relationships and communicate effectively (Tresolini and The Pew Fetzner Task Force, 1994). Relationship centred care acknowledges the importance of individuality, autonomy and personhood. It is founded on morality, a mechanism for guiding collective behaviour through interactions which recognise the person and their humanity (Beach and Inui, 2006; Fernandez and Leze, 2011). This needs to be supported through relationships which recognise interdependence and interconnectedness, within the context of a social world that is founded on a matrix of relationships and prevailing social norms (Nolan *et al.*, 2004). Reciprocity is required between agents, to accept that a balance needs to be sought between independence, dependence and interdependence (Ronning, 2002), enabling nurses to develop effective relationships with individuals experiencing care, their families and the wider multi-disciplinary team. This can be achieved through practices that acknowledge dimensions which promote a sense of security, belonging, continuity, purpose, achievement and significance (Nolan *et al.*, 2004).

Dewar and Nolan (2013) propose that compassionate, relationship centred care is founded on approaches which acknowledge the importance of both the person and the relationship. This includes knowing the person, understanding the person and working with the person through a partnership approach to care. The evidence therefore suggests that individualised, person centred and relationship centred approaches to care are dependent on the nurse's personal attributes and the strategies they implement to involve the individual in their care experience. This includes acknowledging values and beliefs, engaging with the person and facilitating shared decision making within a supportive care context (Nolan *et al.*, 2004; McCormack and McCance, 2010). Thus, it is apparent that nurses need to expose themselves to the emotions of the individuals they are caring for, by engaging in interactive relationships that are founded on the basis of a shared humanity; concepts identified though the earlier literature review of perceptions of compassion.

2.5 Clarifying the Gap in the Literature

Despite evidence from the wide range of contemporary literature discussed so far, there still remains a gap in knowledge to understand compassion. This gap in knowledge primarily arises from a lack of empirical research to explore compassion, specifically from the exclusive perceptions of individuals who have experienced nursing care. If it is accepted that knowledge of relational aspects of care such as compassion can only be elicited through exploration of individual experiences and perceptions (The Kings Fund, 2011; CQC, 2014), it is evidently vital to address this.

The review of the literature throughout this chapter illustrates that compassion is thought to be dependent on a human emotional response, arising from the recognition of another's suffering, vulnerability or distress which leads to an ensuing response to engage in action to alleviate this. Interpersonal skills and personal attributes to facilitate effective communication, partnership, attentiveness, a sense of being present and knowing the person as an individual, are considered to be associated with compassion. However, the majority of empirical research currently informing compassion emanates from a professional or collective perspective, with a limited range emanating exclusively from the individual perspective. This limited range of research is impacted by some methodological and cultural issues, which constrain subsequent utility and resonance with nursing care practice in the UK. Understanding of compassion is compounded further due to the fact that only one piece of empirical research, exclusively focusing on individual perceptions of compassion, has been conducted in the UK context.

Although the wider review of the literature to focus on additional key concepts of relevance to compassion provides some further insight, it fails to explicitly enhance understanding through the specific exploration of individual perceptions of compassion. Undoubtedly, it is evident that the literature reviewed throughout this chapter provides a preliminary insight to inform contemporary understanding of compassion. However, further empirical research is necessary to build upon this to exclusively explore individual perceptions of compassion in nursing in the UK, perceptions which have arisen from, and been constructed through, unique personal experiences of nursing care.

Original empirical research relating to the concept of compassion is limited and until further studies are undertaken a comprehensive insight will remain elusive, leaving nurses lacking a deeper understanding of what compassion involves within the context of nursing (Schantz, 2007; McCaffery and McConnell, 2015). My research addresses the identified gap in the literature, to elicit a more comprehensive insight into compassion from the perceptions of individuals who have personal experience of nursing care in the UK care context. Further research into compassion is required and until a clearer understanding is achieved, nurses will not be able to truly claim compassion as an integral dimension of practice (Olshansky, 2007). It is acknowledged that the perceptions of nurses and other significant stakeholders are of equal importance to establishing an evidence base to inform understanding of compassion in nursing. However, my study specifically aims to provide a foundation of knowledge to represent exclusively, what individuals who have experienced nursing care perceive compassion to involve through implementation of a constructivist grounded theory research approach. It aims to address the research question that was introduced in Chapter 1:

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

2.6 Chapter Conclusion

A stepped approach was taken to conduct the literature review presented in this chapter, commensurate with the ethos of constructivist grounded theory research. Although the literature review evolved through initial and focused phases over the course of the research, it was collated and integrated into this chapter periodically to

provide a foundation to inform the thesis in its completed form. The initial phase of the literature review was conducted prior to commencing the research, supporting the application for ethical approval and contributing to the development of the publication which is presented in Appendix 1. This was subsequently updated following completion of the research, in order to maintain the currency of the review. The initial phase involved an exploration of literature to contextualise compassion and focused on the historical origins of compassion, reported negative experiences of compassion and political and professional reaffirmations of compassion. The focused phase of the literature review was conducted following data analysis. This involved an exploration of literature which informed current understanding of compassion and specifically focused on professional, collective and individual perceptions of compassion, in addition to a range of concepts of significance that had emerged from data analysis. This included concepts such as personality and compassion, learning about compassion, capacity for compassion, leadership and compassion.

The literature review chapter was delineated to reflect the initial and focused phases discussed above, and presented into two overarching themes. These themes focused on ‘contextualising compassion’ to provide background information, and ‘understanding compassion’ to provide an overview of the current evidence base that informs compassion within the context of nursing and a broader range of disciplines. A wide range of literature was reviewed throughout the initial and focused phases, which involved exploring conceptual analyses, discursive commentaries, political policy, professional guidance and empirical research. Although a preliminary insight

into compassion was evident from the literature review, a gap in research knowledge was clearly identified. This gap in knowledge specifically related to a lack of empirical research to explore exclusively, the perceptions of individuals who had experienced nursing care in a UK care context. My research question aims to address this gap in knowledge. The following chapter focuses on the philosophical principles and methodological approach that influence the thesis, and presents an overview of key research methods.

Chapter 3: Research Methodology and Methods

3.1 Chapter Introduction

Chapter 1 established a personal interest and rationale for engaging in the research, whilst Chapter 2 provided a comprehensive review of the topical empirical research and contemporary literature that informs understanding of compassion within the context of nursing and wider disciplines. This led to the identification of a gap in research knowledge, which this study aims to address. Chapter 3 progresses the thesis to consider relevant philosophical and theoretical tenets, discuss the research methodology and provide an overview of key research methods, thus clarifying the theoretical framework that underpins the thesis. Theoretical frameworks are an integral component of robust research practice, providing a foundation to underpin the research methodology and research methods that are subsequently implemented (Miles and Huberman, 1994; Maxwell, 2005; Marshall and Rossman, 2006; Ravitch and Riggan, 2012).

Researchers are required to provide a clear articulation of the philosophies which influence their research practice, offering an insight into their unique orientation to the social world (Miles and Huberman, 1994; Crotty, 1998). This is achieved by assuming a reflexive stance, making explicit the beliefs and assumptions that the researcher brings to the study about the nature of reality and how it can be investigated (Creswell, 2014; Denzin and Lincoln, 2003; Guba, 1990).

Philosophising about the research process lays the foundations for researchers to discover a fundamental understanding about themselves and the world they live in, enabling them to investigate and discover knowledge about often unknown and intangible concepts (Benton and Craib, 2011). Blaikie (2000) refers to this as

developing a logic of enquiry, which fundamentally aims to answer the research question posed in the first instance (Miles and Huberman, 1994). To address these issues, this chapter begins by discussing the development of the overarching conceptual framework which underpins the thesis. The chapter outlines the key tenets of interpretivism, symbolic interactionism and social constructionism, along with the selected research methodology of constructivist grounded theory. An overview of grounded theory research methods is presented, implementation of these methods is discussed in Chapter 4. The associated ontological and epistemological assumptions and how they influence the research approach and design are considered as the chapter progresses. A reflexive activity, offering an insight into my position in the research, and that of my research participants, is also presented to provide transparency regarding existing prior knowledge, experience and insight into compassion in nursing. Cumulatively, this chapter presents the theoretical framework that informs the research (Table 1).

Table 1: Overview of the Theoretical Framework

Philosophical Paradigm	Interpretivism
Ontological Basis	Relativist
Epistemological Basis	Subjectivist
Underpinning Theoretical Perspectives	Symbolic Interactionism Social Constructionism
Research Methodology	Constructivist Grounded Theory
Research Methods	Sampling-Initial and Theoretical Data Collection- Interviews and Focus Groups Constant Comparison Data Analysis-Initial and Focused Coding Theoretical Memos and Diagrams Theoretical Sorting and Conceptual Mapping Theoretical Sensitivity Theoretical Saturation

3.2 Developing the Conceptual Framework

Developing a conceptual framework is essential to provide an underpinning structure to support the implementation of research. Conceptual frameworks do not arbitrarily exist, rather, they are constructed by the researcher as a direct result of questions arising from experience, existing knowledge and exploration of extant evidence (Maxwell, 2005). The conceptual framework provides clarity to the direction of research by identifying what is currently understood about the phenomenon of interest, and locating a focus for the generation of new knowledge to add to this further. It outlines the significance of research in terms of how it links to existing knowledge, policy, practice and the social impact on people's everyday lives (Marshall and Rossman, 2006). It also provides structure to support the research methodology and methods, and acknowledges that the researcher's position in the research process needs due consideration in terms of how this may influence interpretations of the research findings (Miles and Huberman, 1994). Addressing these issues is central to the development of a conceptual framework, and a vital process to enhance the credibility and rigour of research (Ravitch and Riggan, 2012).

The approach taken to construct the conceptual framework underpinning this thesis is founded on the perspective of Ravitch and Riggan (2012). This perspective requires three elements to be addressed which involve personal interest, topical research and the theoretical framework. The conceptual framework is driven in the first instance by emerging questions about a phenomenon, often establishing the primary impetus for research. This involves articulating a personal interest in the topic, requiring the researcher to clarify their existing knowledge and engage in reflexive activity to elicit how their experience, values and beliefs may inform and

impact on their interpretations. A review of topical research and contemporary literature is required, to identify what is already known about the phenomenon and uncover the research methods that have been used to investigate it. This establishes a gap in the literature, provides a robust rationale for engaging in research and identifies the existing theoretical conversations that may inform the topic. These two key elements have already been addressed throughout the discussion presented in Chapters 1 and 2. In order to investigate the phenomenon, it is essential to develop a theoretical framework which acknowledges the formal theoretical perspectives that support the research methodology and methods. This final element of the conceptual framework is addressed throughout the remainder of this chapter. Developing a conceptual framework which addresses these three key elements is instrumental in enhancing the rigour and credibility of research (Ravitch and Riggan, 2012).

It is important to note that the development of the conceptual framework underpinning this thesis was not linear. It emerged through a dynamic and iterative approach which evolved throughout all stages of the research process, occurring simultaneously with data collection and analysis. The evolving nature of the conceptual framework is accepted as an approach which informs, and is informed by, the research process. It is acknowledged that this ensues as a result of changes in the field, emergent evidence from the literature and insights from data collection and analysis (Maxwell, 2012). In its completed form, the conceptual framework underpinning this thesis supports all aspects of the research process, addressing the three key elements identified by Ravitch and Riggan (2012).

3.3 Philosophical and Theoretical Tenets

3.3.1 Interpretivism

The researcher's ability to understand the discourse surrounding philosophical paradigms is vital to support decisions to implement a particular research approach. The underlying philosophical paradigm should be instrumental in guiding the researcher to adopt a specific research approach, the aim of which is to answer the primary research question under investigation (Burrell and Morgan, 1979; Miles and Huberman, 1994). Adopting a research approach involves developing a structured proposal to underpin all aspects of the study and involves critical consideration of philosophical principles, research methodologies and methods (Creswell, 2014). This highlights the importance of ensuring that the researcher is aware of the worldview assumptions that they bring to the research, the research methodology that is most appropriate to use within the realms of this worldview and the particular research methods which need to be implemented to translate this into research practice. The primary research question of this research study is:

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

It is clear that the focus of this research question lies within the perceptions of individuals who have experienced nursing care, and are able to articulate what compassion involves as a result. This indicates that gaining a personal and subjective insight into compassion is the key aim of the research. Compassion is considered to be a complex phenomenon that has different meanings for different people and thus, is dependent on experience and the individual perceptions that are constructed as a result. Through my personal and professional experiential knowledge, this is an

ideology with which I have developed affinity. What I may consider compassion to involve is undoubtedly different to what another may consider compassion to involve. This highlights the subjective nature of compassion, and suggests that it requires investigation by an appropriate research methodology which acknowledges this. The philosophy underpinning this research stems from the interpretivist paradigm, which lends itself to the ontological position that reality is not fixed. Rather, it is dynamic and subjective, constructed by individuals within the context of their social environment (Polit-O'Hara, 2004). Interpretive approaches aim to understand reality as it is perceived at the subjective level of individual consciousness and within the frame of reference of the researched, rather than the researcher (Burrell and Morgan, 1979). This is the primary aim of my research.

As outlined in Chapter 2, a gap in the literature is apparent in relation to exclusively understanding individual perceptions of compassion and in particular, how these perceptions develop through personal and unique experiences of nursing care. Although there was some limited research identified in Chapter 2 which explored individual perceptions, the majority of this was conducted in the USA and Canada, with only one research study located that was implemented in the UK context. Other identified empirical research was noted to focus on professional or collective professional and individual perceptions of compassion. Integrating professional and individual perceptions poses some challenges, due to the research blending these differing perspectives into one collective representation of compassion. This blurs the boundaries between what is currently known about compassion from professional and individual points of view. Methodological and cultural issues also have the

potential to impact on what is currently understood about compassion, particularly in relation to nursing in the UK context. This is compounded further by research which explores the perceptions of other professional groups, thus inhibiting understanding of compassion specifically within the context of nursing. A more comprehensive understanding of what compassion involves exclusively, for individuals who have experienced nursing care is required. To address this, research methodologies which aim to elicit the subjective realities and interpretations of compassion as a result of individual experiences of nursing care, across a diverse and varied range of contexts and environments, are needed.

Interpretivist methodologies aim to understand and explain human and social reality through an inductive approach which takes into account cultural, historical and situated individual interpretations of the world (Crotty, 1998). In relation to the interpretivist paradigm, researchers hold the ontological assumption that multiple realities exist within the context of the individuals being studied, and it is precisely these multiple realities which the researcher desires to uncover (Creswell, 2007). Knowledge is initially constructed in the consciousness of individuals but, ultimately, it can only be effectively generated and understood via collectives of these constructs which seek to reflect the multiplicity of realities and experiences, which are relative to the individual (Moses and Knutson, 2007). Knowledge of the realities of individuals can only be gained through interpretivist approaches which are grounded in subjective experience and meaning (Hughes and Sharrock, 1997). This research aims to uncover the varied perceptions of individuals who have experienced nursing care in order to gain a deeper, and more comprehensive,

understanding of compassion. To achieve this, an interpretive approach is the only justifiable and appropriate research approach to utilise.

3.3.2 Symbolic Interactionism

Interpretivist approaches to research are founded on the meanings and interpretations of individuals to generate knowledge of the social world and uncover knowledge which is often tacit, grounded in symbolic meaning and which is constantly modified by social actors as they interact together. The social world is, in fact, the world as interpreted and experienced from the inside by its members (Blaikie, 2000). This implies that knowledge is generated by dynamic and evolving social processes, wherein individuals are continuously interacting with one another and creating new knowledge and perceptions of the world as they experience it. Humans are constantly experiencing a process of adaption and change as they exist in the social world, and as such, their individual knowledge, insights and perceptions evolve as a direct result (Jeon, 2004).

Blumer (1969) refers to this process as symbolic interactionism; a theoretical perspective or epistemology which focuses on the social aspects of human action, resulting in individual interpretation of the world as a direct result of interactions with other human beings. Handberg *et al.* (2015) assert that it is impossible to separate the individual from the contexts within which they exist, purporting that humans are inextricably linked to the social world. The underlying principles of symbolic interactionism are based on three key premises; humans act towards objects on the basis of the meaning the object has for them personally, the meaning attached to such objects arises from social interaction with fellow humans and this meaning is modified and interpreted by the human dealing with the object as it is

encountered (Blumer, 1969, p2). Through a process of symbolic interaction, individuals constantly analyse the symbolic meaning of the environment around them and the actions of others, resulting in subjective interpretations which evolve into new insights and interpretations (Bryman, 2008). This theoretical perspective is based on an epistemology which focuses on exploring individual and subjective consciousness and ensues in revealing the inner experience, as opposed to that of the world outside (May, 2011). The importance of giving meaning to subjective experiences and perceptions is paramount in striving to know the world, the world as interpreted by individuals as a result of their interactions and encounters with others (Blumer, 1969; May, 2011). This theoretical perspective influences my personal worldview and provides an important contribution to the philosophical principles that inform this research.

In considering the primary research question, it is evident that my study aims to uncover what compassion involves and explore how individual experiences of nursing care contribute to developing their perceptions of this. Through an interactionist process, perceptions evolve through social interactions which lead to the creation of subjective knowledge (Blumer, 1969). Acknowledging this notion led me to conclude that symbolic interactionism was an appropriate theoretical perspective to underpin the philosophical principles of this thesis, and was instrumental in guiding me to select the chosen research design. This perspective lends credence to the presupposition that individual perceptions evolve through varied experiences of nursing care in a range of care contexts, thus contributing to the development of subjective insights into compassion in nursing.

3.3.3 Social Constructionism

A further theoretical perspective influencing my thinking and providing an additional contribution to the philosophical principles that inform this thesis, relates to social constructionism. In academic literature, the terms social constructivism and social constructionism are often used interchangeably, creating confusion and ambiguity (Raskin, 2002). Young and Collin (2004) suggest that it is possible to delineate the terms, whereby social constructivism relates to meaning arising from the cognitive constructions of the individual, and social constructionism relates to meaning arising from constructions developed as a result of social processes and interactions experienced in the social world. In the work of Burr (1996) and Gergen (1999), these terms are used interchangeably throughout, with acknowledgement that there is no one single definition, thus the issue of terminology is deemed insignificant. Within this thesis, the term social constructionism is used without any attempt to delineate the terms as separate entities. Rather, the terminology of social constructionism is used to refer to key theoretical principles which acknowledge the impact of experience and interactions in the social world and the influence this can incur on constructing individual perceptions, resulting in subjective meaning and interpretation.

As previously discussed, the interpretive research paradigm assumes that reality is not fixed, rather it is dynamic and subjective, constructed by individuals within the context of their social environment (Polit-O'Hara, 2004). Socially constructed knowledge is that which is derived from the conceptualisations and interpretations of individuals in relation to their own experiences and actions, the actions of others and the context or situation in which this occurs (Blaikie, 2007). This notion therefore

complements the theoretical perspective of symbolic interactionism and has high utility to interpretive research paradigms, which aim to elicit subjective and relativist perceptions to generate new insights and knowledge of a phenomenon (Clarke, 2005; Gardner, Fedoruk and McCutcheon, 2012).

Humans create and sustain knowledge through the social practices which they engage in, and this is founded on the externalisation, objectification and internalisation of phenomena. Externalisation relates to the sharing of ideas with others, objectification relates to how these ideas subsequently become an object of the inner consciousness and internalisation relates to how this idea is then perceived and accepted by future generations as reality, due to the fact that the idea already exists (Berger and Luckman, 1966). In terms of compassion in nursing, this theoretical perspective led me to assume that compassion in the UK was originally externalised through Christianity, subsequently objectified and translated into professional nursing practice by Florence Nightingale and thereafter, internalised and perceived by society as a core component of the nursing role. The review of the literature in Chapter 2 reflects this assumption and, moreover, the wealth of political and professional literature reaffirming compassion as a core philosophy of nursing provides further evidence that compassion has been perpetuated and internalised within the realms of the social world.

Burr (1996) identifies that knowledge is historically and culturally relative, whilst Berger and Luckman (1966) acknowledge the contribution that religion offers to this. The literature reviewed in sections 2.3.1 and 2.3.2 reflects this, highlighting that

compassion in the context of nursing within the UK has been clearly shaped by historical, cultural and religious influences. It is also suggested that knowledge is dependent on the prevailing culture of the time (Burr, 1996). This is reflected in the literature reviewed in sections 2.3.6 and 2.3.7, which demonstrates an ongoing political and professional commitment to reaffirm compassion in nursing.

Knowledge of compassion therefore appears to be derived from subjective experiences which are influenced by ongoing social interactions. This culminates in the construction of individual and unique perceptions of compassion, which are shaped by history, culture and contemporary social values.

Social constructionism assumes a relativist ontology and a subjectivist epistemology, founded on the assumption that all knowledge is relative and subjective to the individual and their position within the social world (Potter, 2003). This standpoint supports the notion that knowledge generated from those in authority should be refuted, or at the very least accepted with scepticism, due to the influence of power and its potential to skew the reality of this knowledge (Burr, 2003). Cruickshank (2011) suggests that social constructionist perspectives influence researchers to question the authoritarian views and claims of experts, such as health care professionals. To illustrate this, in the work of Skaff *et al.* (2003) discussed earlier, there was clear discordance noted between Physicians Assistant's perceptions of compassion and the views of the individuals they were caring for. This suggested a lack of corroboration between the views of professionals and individuals who had experienced care, therefore strengthening the impetus for this research and offering further support to the philosophical and theoretical tenets which influence the thesis.

3.4 Research Methodology

As identified so far, the philosophical principles of interpretivism, symbolic interactionism and social constructionism were influential factors underpinning the development of this thesis. However, it is also essential to select an appropriate research methodology to facilitate the discovery of new knowledge (Guba, 1990; Denzin and Lincoln, 2003; Creswell, 2014), enhancing insight into compassion in nursing by ensuring that the research question is addressed effectively (Miles and Huberman, 1994). When adopting an interpretative research approach, the researcher is instrumental in constructing knowledge of individual perceptions and interpretations of reality, thus requiring the researcher to assume an emic, or insider approach (McCann and Clark, 2003 a; Blaikie, 2007). It is only by assuming this approach that researchers can demonstrate empathetic understanding of the participant's view of the world, and construct their subjective reality into a collective and meaningful representation. This notion is supported by Denzin and Lincoln (2003, p9) who identify the interpretivist researcher as the 'bricoleur', who interacts with the research process and uses reflexive skills to develop a dynamic, representative construction of the multiple realities of research participants.

Grounded theory methodology is an example of interpretivist inquiry that is founded on such an approach, and which uses strategies to uncover knowledge that is grounded in the constructs and perceptions of individuals. In order to generate knowledge of the individual experience of compassion in nursing, a grounded theory methodology was therefore selected as the most appropriate research strategy to implement. Although other interpretive research methodologies such as phenomenology were considered, one of the primary objectives of my research was

to develop a theoretical representation of compassion within the context of nursing. As phenomenological research merely enables a description of the lived experience, this approach was unable to support theory generation. Grounded theory offers researchers the procedural tools to develop a theory which reflects the perceptions of participants, thus this was selected as the most appropriate approach to answer the primary research question and fulfil the research objectives that were presented in Chapter 1.

3.4.1 Classic Grounded Theory

Grounded Theory is a research methodology initially developed by Glaser and Strauss (1965) during their research to investigate hospital staff interactions with the dying patient, and formally proposed in their book *The Discovery of Grounded Theory* (1967). This radically different methodology evolved in response to Glaser and Strauss's criticisms of research approaches of the time, as they believed that endeavours to verify data were overshadowing the need to generate data (Cooney, 2010). Grounded theory offered a new approach that was more appropriate to study the actions, interactions and social processes encountered by human participants (Creswell, 2007), commensurate with the theoretical perspectives of symbolic interactionism and social constructionism (Clarke, 2005; Charmaz, 2014). It provided an alternative to the methodological approaches that were in vogue at the time, offering a research design to facilitate data generation (Moore, 2009).

Glaser and Strauss (1967) identified the need for researchers to systematically obtain, analyse and inductively discover theory that was grounded in the data itself. It was envisaged that this systematic process would enable researchers to collect data, code data, analyse data and generate theory by the central techniques they

termed theoretical sampling, theoretical memo writing and constant comparative analysis. Researchers would assume an objective position and enter the field without preconceived ideas, interacting with participants to understand their social world. Glaser (2007) asserts that theory generation to explain the phenomena under investigation is the primary aim of grounded theory, whilst Charmaz (1990) suggests that in addition to generating theory, existing theories can be modified or expanded. As time progressed, concerns with grounded theory arose, specifically in relation to the limited direction regarding implementation of the methods (Moore, 2010; Hunter *et al.*, 2011), the notion that researchers could be truly objective when interacting with participants (Charmaz, 1990) and criticisms of the underlying epistemological assumptions (McCann and Clark, 2003 b).

Disparity also arose between Glaser and Strauss with regard to grounded theory procedures and as a result, they elected to part ways. Strauss subsequently proceeded to further develop the methods of grounded theory. Strauss and Corbin (1990) maintained the essence of the original grounded theory in terms of the primary goal being that of theory generation, but expanded this to suggest that by using evolved data analysis methods, theory could also be verified deductively. Their proposed tri level analytical procedures of open, axial and selective coding leading to development of a conditional matrix, offered researchers a more structured approach. The role of the researcher in the research process was also recognised, with later work highlighting the challenge of separating the researcher from the research and the analytical process, thus questioning the ability of the researcher to truly assume an objective position (Corbin and Strauss, 2008).

Glaser (1992) criticised the evolved approach proposed by Strauss and Corbin (1990), considering it to be overly structured, not commensurate with the original ethos of the inductive philosophy of grounded theory and claiming that the analytical techniques had immense potential to ‘force’ the data. This leads to a dilemma for researchers in relation to electing to pursue either a Glaserian or a Straussian approach (Cooney, 2010; Hunter *et al.*, 2011). At the outset of my doctoral journey, I experienced a similar dilemma and was initially unsure of which methodological approach to adopt. Engagement with the grounded theory methodological literature led me to discover an alternative, which offered a more appropriate approach to support my research question and personal worldview.

The constructivist methodological approach provides enhanced flexibility to utilise grounded theory techniques, whilst additionally recognising the integral role of the researcher in constructing theory (Clarke, 2005; Charmaz, 2014). In acknowledging my prior experiential knowledge, understanding and insight into compassion in nursing, I was aware that I was unable to truly separate myself from the research, as required by the Glaserian grounded theory approach. The constructivist approach allowed me to acknowledge this, and rather than reject my previous experience, embrace it as a vehicle to enhance data analysis and theory construction. I perceived the highly structured procedural techniques required by the Straussian grounded theory approach to be limiting and overly prescriptive. Although I desired a level of structure to guide and support my research, I equally determined that flexibility was key. This led to the decision to implement constructivist grounded theory to facilitate construction of a theory to represent compassion in nursing as perceived by the

participants in this research, commensurate with the theoretical perspectives of symbolic interactionism and social constructionism.

3.4.2 Constructivist Grounded Theory

Charmaz (2000, 2006, 2014) provided the constructivist grounded theory approach which primarily underpins the research that is presented in this thesis. This approach facilitates the development of mutual understanding of phenomena, via a collaborative relationship between researcher and participant to construct new knowledge. Acknowledgement of the researcher's existing prior knowledge, experience and insight is key to this process (Hunter *et al.*, 2011) and therefore rejects the Glaserian approach which demands objectivity. The constructivist approach assumes a relativist ontology which acknowledges multiple realities, a subjectivist epistemology which supports the co-construction of knowledge between researcher and researched and draws on naturalistic methodological procedures to uncover this (Denzin and Lincoln, 2003).

Constructivist approaches to grounded theory enable the researcher to address the potential power imbalances of the research relationship and achieve reciprocity to facilitate the generation of a theory, which is grounded in the participant's experiences (Mills, Bonner and Francis, 2006; Mills *et al.*, 2007). Constructivist grounded theory does not simply discover data, rather data and theory is constructed as a direct result of interaction with participants to explore their perceptions and experiences (Charmaz, 2006). It provides a platform from which the researcher can develop understanding of phenomena, offering a subjective and interpretative view of the social world, not an exact replication of it (Charmaz, 2014). This ideology reflects the theoretical tenets of symbolic interactionism and social constructionism

discussed earlier, representing my personal worldview regarding the appropriate approach to explore my research question, and thus, uncover multiple realities of compassion in nursing. Uncovering this knowledge is achieved by adopting a flexible approach to grounded theory techniques, rather than adherence to strict methodological procedures which can inhibit creativity (Charmaz, 2006).

It is suggested that neophyte researchers may find such a flexible approach challenging, due to a lack of a clear and purposeful process (Williams and Keady, 2008; Hunter *et al.*, 2011). As a neophyte researcher myself, the flexibility of the methodological approach advocated by Charmaz (2006, 2014) proved to be a challenging notion at the outset. However, as I engaged further with the methodological literature, I developed an appreciation for this flexibility and found myself rejecting the strict analytical procedures advocated by the Straussian approach. The work of Charmaz (2006, 2014) was instrumental in guiding my research practice in terms of drawing upon her coding and analysis techniques, whilst being mindful of simultaneously maintaining the central ethos of grounded theory methods. My personal philosophical worldview supports the idea that researchers and participants should develop reciprocal relationships to co-construct theory to represent their personal, subjective and individual experiences of compassion in nursing. However, I was also aware that further procedural guidance might be required to enable me to effectively manage the challenges of data analysis and theory generation. I therefore remained open to drawing upon some of the analytical techniques proposed in the situational analysis methods advocated by Clarke (2005).

Clarke (2005) purports that grounded theory methodology is underpinned by symbolic interactionism and social constructionism, claiming that postmodern grounded theorising can only occur when the perspectives of both research participants and researcher are represented. This approach to constructivist grounded theory is founded on original principles, but moves forward data analysis techniques. Clarke (2005) recognises the value of using traditional coding techniques, but rather than using this to achieve a singular and central basic social process, she builds upon the concept of the conditional matrix (Strauss and Corbin, 1990), highlighting the importance of representing multiple social processes and explanations by the method of situational analysis.

Situational analysis aims to enhance data analysis techniques by the development of situational, social worlds/arenas and positional maps which aim to capture and visually represent the complexity of relationships between variables (Clarke, 2005). Although I did not utilise Clarke's analytical techniques in their purest form, I drew upon some of the underpinning principles throughout my research journey. A mapping exercise was conducted to identify the embodiment of both myself and the participants in the context of the research, and is presented in section 3.5 of this chapter. This exercise enabled me to recognise and acknowledge the position of myself as researcher, and the sample of participants, within the overall research process, facilitating a reflexive approach to demonstrate credibility and trustworthiness. Further mapping techniques to advance data analysis were also drawn from Clarke (2005), and are discussed in more detail in Chapter 4.

Researcher reflexivity is key to the constructivist grounded theory approach, which acknowledges that researchers cannot enter the field devoid of prior knowledge (Clarke, 2005; Charmaz, 2006, 2014). Rather, their existing knowledge of the substantive field is considered an integral and valuable asset to facilitate their role as ‘analyst...bricoleur...and cartographer of sorts’ (Clarke, 2005, p xxxvii). Complex and multiple realities of human experience are uncovered by a contemporary grounded theory methodology which does not attempt to claim universality or objective truth. Rather, it seeks to represent a rich analysis of diverse situations and experiences within specific and defined contexts. My research aims to uncover exactly this, the diverse and varied perceptions of a sample of individuals in relation to their understanding of what compassion involves, arising as a result of their experiences of nursing care. My research does not seek to achieve a universal representation of compassion in nursing. Rather, it seeks to provide a rich and meaningful insight into compassion in nursing from the individual perspective, offering an original contribution to knowledge which may have resonance to other individuals in similar contexts.

McCann and Clark (2003 a) argue that whichever grounded theory methodology is adopted, key grounded theory methods need to be addressed. These comprise theoretical sampling, constant comparative analysis, analytical coding techniques, theoretical memoing, theoretical diagramming, theoretical sensitivity and theoretical saturation. Due attention must be paid to the implementation of these methods to ensure credibility and enhance the rigour of grounded theory research (Elliot and Lazenbatt, 2005; Charmaz and Bryant, 2011). The following section provides an

overview of the key methods that are central to grounded theory research, implementation of the methods is discussed in detail in Chapter 4.

3.5 Research Methods

3.5.1 Sampling: Initial and Theoretical

In the first instance, researchers are required to identify a target sample population to locate participants who have unique experience of the phenomenon under investigation (Richards and Morse, 2007; Corbin and Strauss, 2008). Initial sampling decisions can then be implemented in order to gain a general perspective of the phenomenon under investigation. This requires a conceptually driven and reflexive approach, which makes explicit the rationale for subsequent participant selection (Glaser, 1978; Miles and Huberman, 1994; Curtis *et al.*, 2000). Selecting the most appropriate initial participant, who has relevant and wide ranging experience of the phenomenon under investigation, is therefore highly significant. This individual assumes the role of ‘gatekeeper’, and the concepts arising from analysis of their data are instrumental in laying the foundations on which to build further sampling decisions (Cutcliffe, 2000).

Further sampling is guided by the theoretical sampling method, which is pivotal to robust grounded theory research practice. Theoretical sampling is a process of theory generation, whereby the researcher collects and analyses data simultaneously, and as a result of this analysis proceeds to collect additional data to advance development of the emerging theory (Glaser and Strauss, 1967). Charmaz (2006) purports that theoretical sampling is underpinned by an alternative logic to other sampling

strategies, as it is a process to obtain data to develop the emerging theoretical dimensions of the research findings. This is reflected by Corbin and Strauss (2015) who state that the purpose of theoretical sampling is to collect data with the primary aim of capitalising on opportunities to develop categories, uncover variation and elicit links. Theoretical sampling can include interviewing additional participants, adopting alternative interview approaches, exploring recurrent emerging concepts and seeking further data from previous participants to advance emerging categories (Glaser, 1978). It comprises a range of strategies, occurring within a dynamic process that evolves as the research progresses (Charmaz, 2014). This iterative process uses supplementary strategies, such as memo writing, to facilitate the implementation of a strategic and systematic approach to underpin the research process (Charmaz, 2006).

3.5.2 Data Collection: Interviews and Focus Groups

Data collection in grounded theory is most often supported via individual interviews or focus group discussions (Urquhart, 2013). Three key approaches underpin the interview techniques used in qualitative research and involve the structured, unstructured and semi structured method. The structured interview is considered to lack flexibility since it can lead to closed questioning techniques, whilst the unstructured interview, although informal and conversational in nature, can lack focus (Maltby *et al.*, 2010). In grounded theory research, Corbin and Strauss (2008) state that the unstructured interview can give rise to the richest data. However, they acknowledge that this interviewing technique requires higher order researcher skills, so suggest that a flexible topic guide is used to aid focus, supporting implementation of a semi structured approach in the first instance.

Focus groups are often used as a means to generate data, as they are considered invaluable for developing and elaborating categories and theoretical dimensions via an iterative process to enrich the emerging grounded theory (Strauss and Corbin, 1990; Lambert and Loisel, 2008). The focus group discussion offers researchers the opportunity to gain further insight into phenomena by a process whereby participants interact together, collectively constructing and making sense of particular issues (Bryman, 2008). Focus groups usually involve two or more participants engaging in a discussion that is led by the researcher, and are considered to be an effective method of generating meaningful data through participant interaction (Birks and Mills, 2011). Decisions regarding the size of a focus group are dependent on the complexity of the topic, and in circumstances where complex issues are the focus of research, smaller numbers of six to eight are considered to be more appropriate (Redmond and Curtis, 2009). Following a focus group, additional individual interviews can be conducted to advance data collection further. As grounded theory research is iterative, researchers need to assume a flexible approach to data collection. The ongoing and cyclical nature of data collection is a dynamic process, allowing researchers to implement theoretical sampling and return to the field to collect further data, maximising opportunities to elaborate the emerging grounded theory (Charmaz, 2014; Corbin and Strauss, 2015).

The use of digital audio recording devices is a means to obtain a permanent record of the data that is collected through qualitative research. This is a commonly utilised supporting strategy, enabling the researcher to focus on participant interaction to stimulate discussion, rather than being distracted by the process of onerous note

taking (Stockdale, 2002; Given, 2004; Rubin and Rubin, 2005; Fernandez and Griffiths, 2007; Whiting, 2008). Audio recording can inhibit participant comfort levels, potentially impacting on free articulation of experiences and affecting the quality of data (Al-Yateem, 2012). Participant responses can be influenced by a variety of factors, such as the presence of the researcher, individual awareness of being part of a research study or providing socially desirable responses (Patterson, 1994). These factors therefore need to be considered throughout all phases of data collection. Audio recordings are usually transcribed verbatim by the researcher to facilitate immersion in the data (Whiting, 2008; Balls, 2009), or by an independent transcriber in situations where there are time constraints (Duffy, Ferguson and Watson, 2004).

3.5.3 Constant Comparative Analysis

Glaser and Strauss (1967) outline constant comparative analysis as a method which researchers use to make comparisons between the data at all levels of coding as analysis advances. The primary intention of this method is to compare data and incidents to identify similarities, differences and variations, in order to construct a grounded theory. Adopting a sequential approach to compare earlier data with later data is a strategy to clarify existing codes, as well as uncover new codes that may not have fully emerged, which can be followed up by theoretical sampling to collect additional data (Charmaz, 2014). The previous knowledge and experience of the researcher, and their developing theoretical sensitivity, is instrumental to this process as they strive to make analytical sense of the data. Being reflexive about this is essential, so that pre-judgements are not applied to the data, allowing the researcher to remain open to seeing the world through the eyes of their participant (Charmaz, 2006).

3.5.4 Data Analysis: Initial and Focused Coding

Data analysis in constructivist grounded theory is founded on using flexible methods and involves initial and focused coding techniques, which are supported by theoretical memos and theoretical diagrams (Clarke, 2005; Charmaz, 2006, 2014).

An iterative approach is required, which leads to a dynamic analysis whereby coding is not a linear process, rather it occurs simultaneously with data collection. A range of differing terminology is used to describe data analysis in grounded theory.

Whichever terminology is used, the aim of the analytical approach is to elicit concepts, generate categories and construct a grounded theory that is derived directly from the data (Birks and Mills, 2011).

Glaser and Strauss (1967) advocate coding for incidents to identify emerging concepts from the data. This was later termed open coding, a technique to fragment the data and break it down into its component parts, enabling the researcher to make comparisons within and across transcripts (Glaser, 1978). Early coding necessitates a high degree of reflexivity as researchers need to be cognisant of making the right analytical decisions from the outset. This is significant, as early decisions influence future decisions, particularly in relation to theoretical sampling (Strauss and Corbin, 1990). Charmaz (2006) refers to early coding as initial coding. This involves line by line coding that remains closely focused to the original data, using words to reflect actions or processes in the form of gerunds or 'in vivo' codes drawn directly from participant transcripts. Researchers need to remain open to an array of possibilities during initial coding, to ensure they fully uncover the grounded theory emerging from the data. Initial coding involves the researcher working quickly through the

data transcript to identify simple codes, with constant comparative analysis facilitating comparisons across other data transcripts (Charmaz, 2014).

Birks and Mills (2011) identify the next stage of coding as intermediate coding. Charmaz (2006, 2014) refers to this phase of analysis as focused coding. Focused coding identifies frequently occurring initial codes of significance and organises them at a higher level of conceptualisation. This ensues in the development of tentative categories to advance the theoretical direction of the analysis (Charmaz, 2006, 2014). This process allows the researcher to elicit links between emergent tentative categories and highlight gaps in the data to inform theoretical sampling decisions. Charmaz (2014) reiterates that the process is not linear; focused coding does not always immediately follow initial coding, as it is iterative and cyclical throughout the entirety of data analysis, acting as the catalyst to construct the grounded theory.

3.5.5 Theoretical Memos and Diagrams

Constructing theoretical memos is a vital component of advancing data analysis.

Memos are an ongoing and integral part of the analytical process and are necessary for researchers to chronologically record their rationalisations regarding what they perceive the data to be revealing (Charmaz, 2006, 2014). Researchers often need to memo at unanticipated and inconvenient points, but if this approach is not taken, data revelation can wane and the grounded theory can fail to develop (Stern, 2007).

Memo writing is the crucial methodological link which enables researchers to transform the data into a grounded theory. This involves a process of organising, analysing and interpreting the social world of participants and documenting researcher insight and understanding into this, as and when it emerges (Urquhart,

2013). The memo is a written record of the researcher's unique internal reflexive analysis and provides the opportunity to formulate ideas and insight, thus enhancing elaboration and construction of the grounded theory (Lempert, 2007). Theoretical memos are the pivotal step in transforming the raw data to an advanced level of theoretical abstraction, as the researcher constantly analyses ideas and interpretations as they interact with the data (Charmaz, 2014).

Theoretical abstraction can be supported by drawing theoretical diagrams to identify potential links between codes and tentative categories. Diagramming provides a visual representation of the researcher's ideas, which are often an extension of theoretical memos and can be integral to grounded theory construction (Charmaz, 2014). Implementing diagramming techniques can offer a methodological tool to advance the theory in terms of developing a conditional matrix (Strauss and Corbin, 1990), or situational, social world and positional maps (Clarke, 2005). However, this can impose restrictions on data analysis and inhibit the construction of a theory that is grounded in the data (Hernandez, 2008). Researchers can opt to use diagramming strategies as they feel appropriate, but in doing so, caution must be taken to avoid 'forcing' the data to fit the specific technique (Glaser, 1992). A flexible approach is therefore advocated in constructivist grounded theory approaches. Researchers are advised that diagrams should be founded on developing a visual representation of their emerging conceptualisations, rather than 'forcing' the emerging theory to fit an existing framework (Charmaz, 2014).

3.5.6 Theoretical Sorting and Conceptual Mapping

Data analysis can be advanced further by a process of theoretical sorting and conceptual mapping. Analytical advancement can be achieved by theoretical coding,

which involves applying an analytical framework to reconstruct the fragmented data into a comprehensible representation of views by drawing upon existing major extant theories (Glaser, 1978). Applying such a prescriptive coding framework can, however, limit the ensuing grounded theory and diminish the emerging originality in favour of existing theories, potentially ‘forcing the data into old boxes’ (Charmaz, 2014, p153).

Theoretical sorting is therefore advocated as a means to organise and integrate theoretical memos and diagrams that have emerged from initial and focused coding, into a coherent grounded theory. This approach encourages simple coding strategies, which enable the researcher to remain open and reflexive to what is emerging from the data (Charmaz, 2006). A further strategy to advance analytical abstraction is founded on conceptual mapping techniques (Clarke, 2005). Mapping techniques provide a visual aid to open the researcher’s mind to view the data from an alternative perspective, enhancing explication of links to construct the data into a robust and refined grounded theory. Mapping supports consideration of human and non-human factors to identify issues such as *who and what is in the situation? who and what matters? what factors make a difference?* (Clarke, 2005). The fundamental aim of mapping is to enable the researcher to visually illustrate the key concepts arising from the data, and examine possible relationships. A reflexive approach is required to consider each concept in turn to determine how they relate to one another, therefore generating new insights and supporting construction of the grounded theory.

3.5.7 Theoretical Sensitivity

Theoretical sensitivity involves becoming sensitive to the data to comprehend the emerging research findings. It relies on the researcher's existing knowledge and ongoing exposure to theory, which contributes to constructing interpretations of what the data is revealing. Glaser and Strauss (1967) describe theoretical sensitivity as the researcher's ability to develop theoretical insight into the research, enabling extraction of significant concepts from the data (Strauss and Corbin, 1998).

Theoretical sensitivity requires the researcher to adopt a reflexive stance which facilitates theorising, thereby discerning the possibilities of what the data is revealing (Charmaz, 2014). Grounded theory coding techniques are integral to facilitating this, and implementing analytical processes via in depth data analysis are necessary to achieve it. To advance theoretical sensitivity, it is necessary to draw upon the constant comparative analytical method, supporting the researcher to compare data with data, code with code, category with category (Charmaz, 2006).

3.5.8 Theoretical Saturation

Robust data collection and analytical strategies are essential to support achievement of theoretical saturation, a key aspect of grounded theory methods that is supported by theoretical sensitivity (Urquhart, 2013). Glaser and Strauss (1967) developed the concept of theoretical saturation as an indicator to guide researchers when to cease theoretical sampling and data collection. Theoretical saturation is said to be achieved when new codes fail to emerge from data analysis, and the researcher considers category development to be conceptually complete (Strauss and Corbin, 1990).

Theoretical saturation relies on an iterative process, throughout which data collection and analysis occur simultaneously until the researcher determines that gathering additional data is failing to generate new insights, and theoretical categories are deemed to be robust (Charmaz, 2006). Bowen (2008) states that rather than striving

for theoretical saturation, the focus should be on striving for ‘theoretical adequacy’. Dey (1999) argues that the term theoretical saturation is misleading and proffers an argument for claiming ‘theoretical sufficiency’, whereby rather than saturating categories with extensive amounts of data, categories are suggested by the data. The goal is for researchers to achieve an analytical conceptualisation of the data, raise the level of theoretical abstraction and develop a robust grounded theory which is representative of the research findings (Dey, 1999; Charmaz, 2014).

3.6 Reflexivity: Researcher and Participant Embodiment

Within the interpretivist paradigm, reflexivity is an integral part of implementing robust research practice and ultimately, enhancing trustworthiness. Engaging in reflexivity is a means to acknowledge the researcher as the central figure who collects, interprets and constructs a representative view of the research findings (Finlay, 2003). In the absence of a reflexive approach, qualitative research is considered to be incomplete and lacking in trustworthiness (Bonner, 2001). The reflexive process acknowledges that meaning is negotiated within a particular social context, and that other researchers may discover alternative perspectives (Finlay, 2003). Reflexivity offers a positive contribution, which can transform the challenges that the researcher may face into an opportunity for enlightenment (Finlay, 2002). It is underpinned by a variety of approaches, but whichever is taken, the primary aims are to:

- Explore the impact of the position, perspective and presence of the researcher
- Promote insight through examining personal responses and interpersonal dynamics

- Uncover unconscious and implicit biases
- Evaluate the research process, method and outcomes
- Facilitate scrutiny of the integrity of the research to enhance trustworthiness

(Finlay, 2003, p16).

Throughout this research, reflexivity was used on an ongoing basis to support decision making and enhance credibility and trustworthiness of the study. Reflexion on a variety of issues occurred during the research journey, some of which will be explored as the thesis progresses. Assuming a reflexive approach to clarify and acknowledge my position in the research was vital at the outset of the journey, in order to appreciate the potential influence of this on assimilating the research findings, and constructing the propositional grounded theory.

Commensurate with the philosophy of constructivist grounded theory, the notion that the researcher enters the field as an objective being, free from prior knowledge, experience and insight is rejected (Clarke, 2005; Charmaz, 2006, 2014). In acknowledgement of this, Dey (1993, p229) asserts that the researcher comes to the field with ‘an open mind, not an empty head’, drawing on theoretical sensitivity to construct a grounded theory which can be further refined through future additional empirical investigation. However, in order to maintain the trustworthiness of constructivist grounded theory research, it is essential that researchers make explicit the existing knowledge, experience and insights that they bring to the research arena and document this for clarity (Charmaz, 2000; Neill, 2006). Clarke (2005) asserts that all those involved in the research process are embodied by their very existence in the social world. This includes participants who have existing knowledge,

experience and insight which also has the potential to influence research outcomes. If constructivist grounded theory approaches are founded on the co-construction of knowledge, clarifying this existing knowledge is essential to acknowledge the positions of all those who contribute to the research as ‘embodied knowers’ (Clarke, 2005, p21). This requires a reflexive approach to acknowledge the contribution of previous knowledge gained in the social world (Cutcliffe, 2003).

Such a reflexive approach was implemented to conduct a mapping exercise, to establish my personal embodiment and position in the research. This clarifies my prior knowledge, experience and insight into compassion and the potential for this to impact on constructing the grounded theory that emerged from this research. Although I was unable to assume such a detailed reflexive approach to my participant’s prior knowledge, experience and insight, I was able to consider aspects of this as a result of the collaborative and reciprocal relationships I developed with them throughout the research journey. Although not a complete reflection of their embodiment, the exercise enabled me to consider and reflect on the knowledge, experience and insight I was aware they possessed, and the potential impact of this on their position within the research (Table 2).

Table 2: Researcher and Participant Embodiment

Individual Researcher Embodiment	Individual Participant Embodiment	Shared Researcher and Participant Embodiment
Senior Lecturer in Undergraduate Adult Nursing with over 11 years' experience.	Member of existing university group to share and discuss care experiences with undergraduate nursing students.	Awareness of a variety of negative care experiences due to ongoing media coverage.
Registered Nurse and Registered Midwife with extensive experience in the professional care context.	Ongoing engagement with public involvement healthcare forums, voluntary and charitable organisations.	Individual insights into compassion arising from personal experiences of nursing care.
Knowledge of contemporary professional, political, conceptual and empirical literature related to compassion.	Diverse range of experience in current and previous professional and informal caring roles.	Individual insights of compassion arising from family members and other vicariously observed experiences of nursing care.

It is essential to clarify that the emergent propositional grounded theory that is introduced in Chapter 6, is grounded entirely in the research data that was collected during this study. It must also be acknowledged that this theory has been developed and constructed as a result of the embodiment of both researcher and participant, arising from combined existing knowledge, experience and insight into compassion within the context of nursing. The constructivist grounded theory approach accepts that this embodiment is an integral component of the research process. Embodiment is instrumental in facilitating the generation of new knowledge and should be regarded as a strength, rather than a limitation (Charmaz, 2006, 2014). Drawing upon prior knowledge has been an essential pre-requisite to make sense of the complex myriad of concepts that have emerged from this research. Without it, I would envisage an almost impossible task to comprehend and represent the complexity of

participant perceptions, and thus achieve the level of insight that was required to support the construction of the propositional grounded theory.

3.7 Chapter Conclusion

This chapter has presented a detailed discussion of the theoretical framework that influences this thesis, a key component of developing the underpinning conceptual framework that was discussed at the outset of the chapter (Ravitch and Riggan, 2012). An overview of the philosophical and theoretical tenets of interpretivism, symbolic interactionism and social constructionism were presented. This culminated in identifying that knowledge is subjective, dynamic and interpreted by individuals within the context of the ongoing situations and interactions that they experience with others. Grounded theory was discussed as an interpretive research approach to uncover subjective knowledge, and a rationale for implementing a constructivist grounded theory methodological design was presented. Throughout the chapter, a reflexive approach was taken to clarify my personal world view, providing transparency to the research approach taken and acknowledging the potential influence of my embodiment in terms of prior knowledge and experience. Assuming this reflexive approach also extended to considering the knowledge and experience of participants, to additionally recognise their embodiment.

An overview of key grounded theory methods was discussed, introducing issues such as initial and theoretical sampling, initial and focused coding, theoretical memos and diagrams, theoretical sensitivity, theoretical saturation and constant comparative analysis. The following chapter provides a comprehensive and detailed

discussion of the implementation of grounded theory research methods, as they were applied within the context of the research that is presented in this thesis. Ethical issues are explored and the target sample population is clarified. The chapter goes on to discuss sampling, data collection and data analysis, and also clarifies decision making in relation to issues such as theoretical sampling and theoretical saturation. This discussion provides a comprehensive audit trail, in order to provide assurance of the credibility and trustworthiness of the research. The chapter concludes with a reflexive account of key issues related to the target sample population, selection of the initial participant for data collection and location of the interviews.

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Chapter 4: The Research Journey

4.1 Chapter Introduction

The previous chapter outlined the philosophical and theoretical tenets that influence this thesis, discussed the chosen research methodological design of constructivist grounded theory and provided an overview of the key methods that are central to grounded theory research. The chapter clarified my personal world view and a reflexive approach was taken to consider the embodiment of myself and the participants who contributed to the research, in order to elucidate prior knowledge and experience of compassion in the context of nursing.

This chapter presents a comprehensive discussion of the constructivist grounded theory research methods that were implemented throughout this study. Ethics is addressed in the first instance, to outline how ethical principles were applied and implemented during the research process. The sampling strategy is discussed to consider the target sample population, the utilisation of a sampling questionnaire and the assimilation of a sampling matrix, which provided a preliminary foundation for theoretical sampling. The process of theoretical sampling is elucidated, and issues related to theoretical saturation and constant comparative analysis are outlined. The data collection strategies of individual interviews and a focus group discussion are discussed, and a comprehensive overview of the data analysis strategies which involved initial, focused and advanced coding techniques are presented. Examples of reflexive activity to deliberate key issues related to the target sample population, the initial participant selected for data collection and location of the interviews are considered. Overall, the chapter provides a rigorous and robust account of the

research journey that was undertaken, providing a clear and comprehensive audit trail. The chapter concludes by considering key aspects of the research process to establish credibility and trustworthiness of the study.

4.2 Research Ethics

4.2.1 Ethical Principles

Research ethics is an essential and integral component of all contemporary research practice, constituting a moral responsibility for researchers towards their participants (Ryen, 2016). A reflexive approach is required to assure ethical inquiry which informs the conduct of research, protects human participants and promotes the integrity of the research process (May, 2011). The primary concern of any research activity is to ensure that the privacy, dignity, rights, wellbeing and safety of participants is paramount. The principle of informed consent lies at the core of this, thus it is essential to ensure that research participants are fully informed about the plan and purpose of research and based on their understanding of this, freely agree to participate (DH, 2005 d; ESRC, 2010).

To fulfil these ethical obligations, a reflexive stance was adopted to address key ethical issues before, and throughout, the implementation of the research process. Four key ethical principles underpin research, comprising respect for autonomy, non-maleficence, beneficence and justice (Beauchamp and Childress, 2008). These ethical principles supported the development of a research ethics protocol, to ensure that participants were protected from harm, were fully informed about the purpose of the research, gave informed consent to participate and were aware of their ability to

withdraw from the study at any point without consequence (ESRC, 2010). All organisations involved in research must take responsibility to develop and promote a high quality research culture, via robust systems which facilitate independent ethical scrutiny (DH, 2005 d). Thus, a comprehensive application for ethical approval to conduct the research, was submitted to obtain expert appraisal and formal permission to proceed. The research did not commence until this was confirmed (Appendix 4).

4.2.2 Obtaining Informed Consent

In order to recruit research participants, it is imperative to provide appropriate information about the proposed research and obtain informed consent. To facilitate this, researchers are required to provide adequate information about the plan and purpose of research to prospective participants, enabling them to reach an informed decision regarding their participation (Bryman, 2000). The process of informed consent is consistent with individual autonomy and can only be achieved when participants agree to participate voluntarily, and without coercion, based on their understanding of clear and accurate information (Christians, 2000). The issue of informed consent is supported by research ethics governance, and identified as an integral and essential aspect of ethical research practice (DH, 2005 d; ESRC, 2010).

In order to ensure that prospective participants were fully informed about the purpose and plan of the research, letters of invitation to participate (Appendix 5), accompanied by a detailed research study information leaflet, were disseminated (Appendix 6). The research study information leaflet provided detailed information to support prospective participants to make an informed decision regarding their participation. To ensure that the principle of justice was maintained (Beauchamp and Childress, 2008), the leaflet outlined the participant's right to withdraw from the

study at any point, without recourse or consequence. Houghton *et al.* (2010) reiterate the significance of promoting participant autonomy, highlighting that participants must be allowed to assume responsibility for decisions relating to ongoing participation, without the fear of repercussions (Polit and Tatano Beck, 2006).

The information leaflet clarified risks and benefits of participating in the study, addressing the principles of beneficence and non-maleficence (Beauchamp and Childress, 2008). Researchers must be mindful of the risk-benefit ratio of research practice and take appropriate steps to minimise any identified associated risks (Houghton *et al.*, 2010). In this research, no significant risks were identified for participants as data collection was focused upon story telling of personal experiences of compassion in nursing. It was recognised, however, that in depth interviews may result in participant's re-living experiences whereby care had not been perceived as compassionate, potentially resulting in anxiety and distress. In such circumstances, researchers must be prepared to support participants, directing them to seek appropriate professional interventions such as counselling (Ensign, 2003; Oliver, 2003). As an experienced Registered Nurse, Registered Midwife and Nurse Academic, I considered myself to possess the appropriate skills to support participants through any emotive issues arising from the interview process. However, I also recognised my personal and professional limitations and considered that I needed to remain mindful of the potential requirement to direct participants to seek appropriate support as required. The need for this did not arise.

Prospective participants were encouraged to reflect on the information in the leaflet, consider the key principles and then make contact as required to obtain further information or discuss individual queries. Individuals who were willing to participate were requested to return an initial consent form (Appendix 7), as an indication of their consent to participate in the next stage of the research. Providing prospective participants with adequate time to reflect and consider their decision to participate in research is good practice. This facilitates the opportunity to gain further information or pose questions, a strategy that is supported as a means to ensure that full informed consent is gained (DH, 2005 d). Prospective participants require accurate and understandable verbal and written information, and the use of written informed consent forms can enable participants to be fully aware of the implications of taking part in research from the outset (RCN, 2004; Bryman, 2008). A small number of individuals made contact by telephone to seek clarification for minor queries, contributing to their individual informed decision to participate in the research. Queries related to issues such as the relevance of personal experiences and how these may contribute to the research, in addition to the location of interviews and the amount of time required to commit to the study.

Ethical issues were addressed throughout the entire research process. For example, ongoing consent was obtained to ensure that participants remained willing to be included in the study, a key aspect of ethical research practice (Holloway and Wheeler, 2002). This was achieved by gaining further written consent prior to individual interviews (Appendix 8) and the focus group discussion (Appendix 9). All participants gave ongoing consent throughout the research process and none invoked

their right to withdraw their data. Due to ongoing health issues, a small number of participants withdrew at a later stage, but consented for any data they had already shared to be included in the research. Gaining consent in these circumstances ensured adherence to key ethical principles (DH, 2005 d; ESRC, 2010).

4.2.3 Maintaining Confidentiality

Confidentiality is a key requirement of ethical research, therefore the anonymity of participants must be maintained at all times during processing and storage phases of the research process as a primary safeguard (Christans, 2000; DH, 2005 d; ESRC, 2010; Ryen, 2016). Maintaining confidentiality is also an integral part of the professional conduct required of Nursing and Midwifery Council (NMC) registrants. Therefore, all participant's personal information and data was managed in line with the NMC Standards of Conduct and Performance (NMC, 2008 b; NMC, 2015 a). To achieve this, participants were reassured both verbally and in written format via the information leaflet, that their identity would remain anonymous throughout the study.

Throughout the research process, personal information and research data was protected. Hard copy documents were stored in a locked filing cabinet and electronic documents were stored on the secured university network, facilitating adherence to the principles of data protection (Data Protection Act, 1998). Further strategies to maintain confidentiality of participant information were implemented prior to data collection. All participants were allocated a unique identifying code which was immediately assigned to their personal information and any subsequent data that was generated from individual interviews or the focus group. Following data collection, digital audio recorded data was uploaded to the secured university network and all

transcripts were anonymised by removing any personally identifying information. The RCN (2004) support strategies to maintain confidentiality, highlighting that good research practice ensures that identifying codes or pseudonyms are assigned to participant data to ensure anonymity.

Research participants were informed that although their identity would remain anonymous, presentations or papers produced as a result of the research might replicate phrases from the data in the form of quotations. The RCN (2004) support this approach, advocating that the identity of research participants must never be identifiable in any dissemination activity. It was, nevertheless, essential to clarify my position as a professional registrant. All participants were therefore informed at the outset that I was bound by Nursing and Midwifery Council (NMC) professional standards, and made aware that any information disclosed during the process of data collection which raised professional issues, would need to be managed in line with my professional responsibilities (NMC, 2008 b; NMC, 2015). The need for any such disclosure did not arise.

4.3 Sampling the Participants

4.3.1 The Target Sample Population

The target sample of prospective participants identified for inclusion in the research were members of an established University ‘Service User and Carer’ group based within the Faculty of Health and Life Sciences. The group consisted of thirty-six individuals who had experience of health and social care across a diverse range of contexts and environments. As members of the group, they were actively involved in

sharing their personal experiences with students, as an integral teaching and learning strategy of the undergraduate nursing curriculum. Collaborative working partnerships had been established with the group members in response to government initiatives to facilitate service user contribution to undergraduate nurse education (DH, 1999; DH, 2004; DH, 2005 a b c; DH, 2010 c).

A variety of approaches had been implemented to recruit the group members. For example, some individuals were recruited following conferences where they had presented a narrative of their personal experiences of nursing care. Others were recruited through established networks with local voluntary agencies or support groups. Strategies to enable individuals to share their personal experiences of care are advocated as an effective approach to enhance the quality of nurse education (DH, 2005 b c). This ensures that the individual voice is heard and students are provided with opportunities to learn from others, equipping them with appropriate knowledge and skills to inform future practice (Quality Assurance Agency (QAA), 2005; Simpson, 2006). Gaining individual perspectives from personal narratives offers the nursing profession a unique opportunity to gain a deeper and richer understanding of emerging issues in the contemporary care arena (Launer, 2002).

A key element of grounded theory is that researchers must be guided by their research question to identify an accessible target sample population, to locate participants who have unique experience of the phenomenon under investigation (Richards and Morse, 2007; Corbin and Strauss, 2008). By their definition as a group of individuals who had identified themselves as having experience of nursing care

across a diverse range of care contexts, it was assumed that these individuals would be able to offer a rich insight into compassion in nursing. Some limited previous experience with these individuals in my academic role had indicated this, during observations of their educational interactions with students which demonstrated a profound level of reflection, insight and understanding of their personal experiences of nursing care. This placed them in a unique position to contribute to the research, supporting development of a more comprehensive insight into the complex nature of compassion in the context of nursing (Charmaz, 2014).

Although it is important to locate an appropriate target sample population in grounded theory research, it is essential to move beyond this (Corbin and Strauss, 2008). Researchers are required to identify a group of information rich participants with maximum variation of characteristics and experience, to determine concepts and themes that are evident across the group in relation to the phenomena under investigation. This requires grounded theory researchers, initially, to identify characteristics across the sample population to inform individual sample selection (Morse, 2007). Maximum variation sampling strategies result in the collection of high quality, unique and detailed data which identifies shared themes and variations which are significant because of their emergence from a heterogeneous sample (Patton, 1990). Diverse samples are favoured in grounded theory research as a means to collect rich data and uncover varied and wide ranging concepts, as narrow samples are thought to inhibit the scope of the data (Hutchinson, 1993). Glaser and Strauss (1967) suggest that sampling in grounded theory requires researchers to seek out research participants with appropriate knowledge and experience, thus facilitating

theoretical sampling, an integral grounded theory method (Charmaz, 2006, 2014). In order to support this, a sampling questionnaire was utilised.

4.3.2 The Sampling Questionnaire

A sampling questionnaire was developed to primarily identify if participants had experience of nursing care, in addition to identifying a range of additional characteristics and criteria (Appendix 10). This strategy sought to capture information related to gender, age range, context where nursing care was experienced and length of time elapsed since the experience had occurred. Participants were also invited to rate their overall experience of nursing care and compassion on a Likert Scale ranging from 1 to 10; 1 being poor and at the lower end of the continuum and 10 being excellent and at the higher end of the continuum. The aim of the sampling questionnaire was to collect baseline information which could support initial and early theoretical sampling decisions. It was developed as a combined result of existing theoretical sensitivity arising from my professional experience (Glaser, 1978) and emerging insight arising from the initial phase of the literature review (Charmaz, 2014).

Survey tools have been used in previous research to identify participants who possess the primary characteristics under investigation (Mishna, 2004; Raj, Silverman and McLeary-Sills, 2005). However, although these tools collated information to give clarity to the sample, they failed to draw upon the information to guide sampling decisions. Mactavish and Schlein (2004) utilised a questionnaire to identify principal participant characteristics, providing a foundation for sequential purposive sampling. Currie (2009) built upon this technique further, using an initial questionnaire as an aid to inform theoretical sampling. Schatzman and Strauss (1973)

highlight that it is imperative to identify a primary target sample prior to data collection. However, it is essential that grounded theory researchers move beyond this target sample, and implement a strategy which facilitates a sequential approach to theoretical sampling (Draucker *et al.*, 2007). Machin, Machin and Pearson (2012) advocate such a strategy, identifying that a sampling matrix is a valid technique to seek maximum variation from the sample and support researchers to implement theoretical sampling.

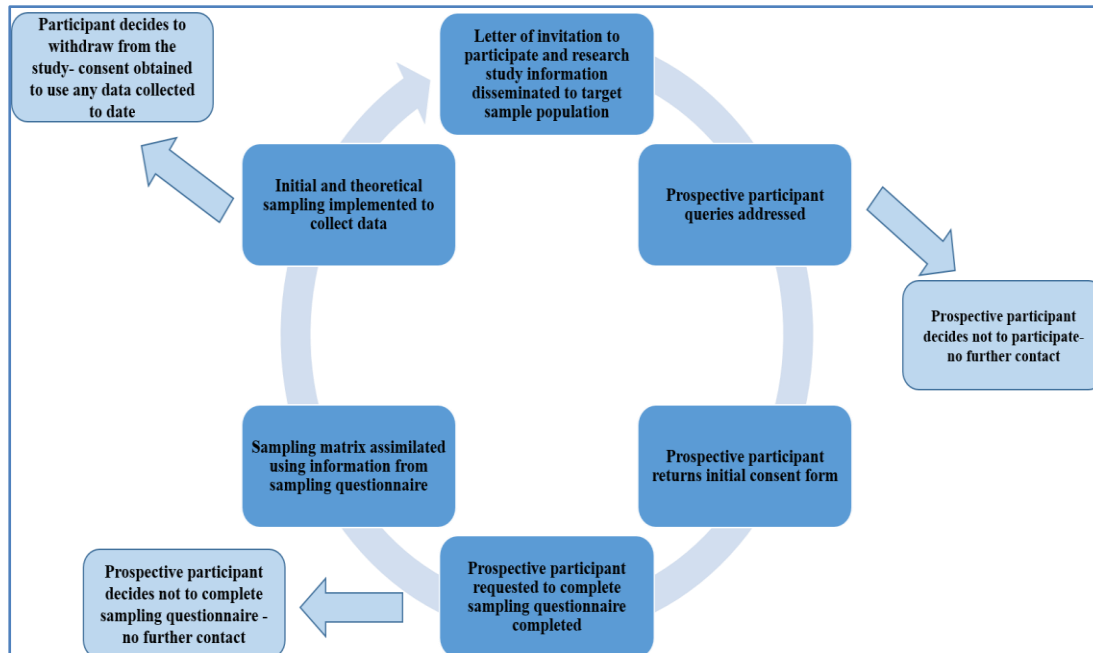
4.3.3 Assimilating the Sample Population Matrix

Following dissemination of letters of invitation to participate to the target sample population, twenty of the thirty-six group members returned completed initial consent forms. At this point, prospective participants were invited to complete the sampling questionnaire. Of the twenty individuals who returned their initial consent to participate, sixteen proceeded to return the questionnaire. The questionnaire captured fundamental participant information to support identification of individuals with relevant experiences to inform the research. This information was collated and assimilated into a sampling matrix (Machin, Machin and Pearson, 2012), to delineate the range and variety of the sixteen prospective participant's characteristics and experiences (Appendix 11).

Sampling is an iterative process, driven by a conceptual question that leads researchers to choose participants to elucidate a range of experiences (Miles and Huberman, 1994). The sampling matrix supported identification of the diverse range of individual experiences of nursing care, which had occurred at different times and in different contexts. This assisted in primarily uncovering similarities and differences between individuals, and when assimilated, the matrix provided a

preliminary platform to support initial and theoretical sampling decisions. The diagram in Figure 6 illustrates the sampling process.

Figure 6: The Sampling Process



4.3.4 Implementing Initial and Theoretical Sampling

To progress the research, it was necessary to draw upon the sampling matrix to make an informed decision to identify the most appropriate participant for initial interview (Glaser, 1978; Miles and Huberman, 1994; Curtis *et al.*, 2000). The initial participant was female, in the 80 plus age range and had experienced nursing care across a wide range of health care contexts. Her experiences had occurred within the last 5-10 years and she had indicated that her overall perception of nursing care and compassion was positive, rating them both at the level of 8. It was assumed that the scope of experiences this participant had encountered could generate data that would serve as a foundation on which to base further theoretical sampling decisions. In addition, my personal instinct guided me to consider that it was important to commence data collection with an individual who had identified a positive

experience of nursing care, in order to uncover her perceptions of what compassion involved.

Selecting a participant with a wide scope of relevant positive experiences of the phenomenon under investigation, and who can potentially provide rich data, is a strategy to identify the primary research ‘gatekeeper’ (Cutliffe, 2000). Older people are often excluded from research in favour of a more tokenistic approach, as they are considered to be a difficult group to target due to issues related to health, time and resources to participate (Faugier and Sargeant, 1997). Involving older people in research can be empowering for the individual and can benefit wider society, by enabling others to learn from their experiences (Fudge, Wolfe and McKevitt, 2007; Walker, 2007). Walker (2007) suggests that if the fundamental purpose of research is motivated by a desire to develop knowledge to enhance the quality of care for older people, their involvement in the research process is vital. The review of the literature to contextualise compassion presented in Chapter 2, identifies negative experiences of compassion in nursing to be a significant issue arising from the experiences of some older people. Therefore, it was deemed important to ensure that the voice of the older person was heard. Further participants were identified through a theoretical sampling strategy (Appendix 12), which guided data collection to select participants with the potential to develop the emerging grounded theory (Glaser and Strauss, 1967; Charmaz, 2006; Corbin and Strauss, 2015). Although the completed sampling questionnaires of 16 potential participants were collated and assimilated into the sampling matrix (Appendix 11), not all were selected to contribute to the research. The decision for this was influenced by circumstances which indicated strong

similarities between potential participants, particularly in relation to issues such as gender, age range or context where the care experience had occurred.

To facilitate theoretical sampling, data analysis needs to be timely. In the most authentic grounded theory studies, preliminary analysis is completed before further data collection, although it is noted that this is not always practicable in the complex field of research (Birks and Mills, 2011). Despite this potential challenge, this was the approach I adopted. Initial data analysis was completed after each interview to identify emerging codes and develop tentative categories, supporting the process of theoretical sampling through reflexive decision making for succeeding data collection (Charmaz, 2006, 2014). This did give rise to issues in relation to the pace of data collection, as the process of transcribing and analysing the data had an impact on the momentum of the research. As a result, data collection occurred over a prolonged period of time, between the months of December 2012 to August 2015. This highlights that theoretical sampling was highly dependent on the emerging data analysis. Strong links between analysis and sampling in grounded theory are inevitable, therefore I was aware that I needed to embrace this to ensure that I rigorously applied the methods of this research approach (Draucker *et al.*, 2007).

In the early stages of the research, the sampling matrix provided preliminary participant information to support theoretical sampling decisions. As the research progressed however, the sampling matrix proved to be of less utility, and data analysis of previous interviews became more significant in guiding theoretical sampling decisions. Strauss (1987) highlights that theoretical sampling often

involves a degree of calculated and creative decision making, in order to discern the most appropriate direction of data collection to develop the emergent theory. A reflexive approach to the decision making process was therefore adopted to facilitate the formulation of rationales to support ongoing sampling (Charmaz, 2006), and documented in my research journal. Documenting the rationale for decisions made in relation to theoretical sampling is good practice, as it provides transparency to the research audit trail (Draucker *et al.*, 2007). Theoretical sampling should be implemented in the early stages of research and throughout, following engagement with data analysis to formulate tentative categories, which the researcher aims to develop and refine (Charmaz, 2014). In this research, in the early stage of the process theoretical sampling was informed by aspects of both the sampling matrix and analysis of the data. However, as the research progressed, theoretical sampling was solely informed by the evolving analysis of the data. Theoretical sampling was primarily underpinned by the aim to explicate tentative categories, develop the properties of these and construct the propositional grounded theory. Appendix 12 provides a full account of the decisions made in relation to the theoretical sampling strategy that was implemented in this research, providing clarification of the specific participants who were involved in all stages of data collection.

Theoretical sampling involved selecting new participants from the sampling matrix who had the potential to offer insight into issues identified from previous data, re-interviewing participants identified as having the potential to explicate the emerging tentative categories and making minor refinements to add further questions to the interview topic guide (Glaser, 1978; Charmaz, 2014). Modifying and refining

interview guides is a technique used by many researchers as a means of theoretical sampling, but this process is often not clarified (Draucker *et al.*, 2007). In order to afford transparency in relation to interview guide refinements, Appendix 13 presents the initial interview topic guide that was used to support data collection and includes some additional questions to clarify the iterative nature of this process.

4.3.5 Characteristics of the Sample

It is important to clarify the characteristics of the final sample to support trustworthiness, particularly in relation to enabling others to determine resonance of the research findings to individuals in similar situations (Charmaz, 2014). Table 3 provides an overview of the final sample, which comprised eleven participants from the target sample population, all of whom were identified through the initial and theoretical sampling processes discussed in the previous section. The table provides information regarding each participant's age range, gender, background, time elapsed since their care experience and the data collection method/s that they participated in.

Table 3: The Sample

Participant	Age Range	Gender	Background	Time Elapsed Since Experience	Data Collection Method
1	80+	Female	P1 was a retired medical receptionist who had worked in a GP practice. She had experienced a range of nursing care experiences, across diverse contexts. She was also an active member of some local voluntary agencies, involved in CQC hospital and care home inspections to provide a lay perspective and actively contributing to pre- registration nurse	2-5 years	Individual interview

			education teaching and assessment.		
2	51-65	Male	P2 was a recently retired financial consultant. He had only experienced nursing care during one hospital admission, involving a prolonged stay in ICCU and rehabilitation on a medical ward.	3-6 months	Individual interview Focus group discussion
3	51-65	Female	P3 did not work in active employment. She had been born with a congenital birth disability and as a result, was wheelchair bound. This disability had resulted in numerous experiences over a life time of care interventions. She had experienced nursing care in a diverse range of contexts, including her own home where she privately employed a carer to support her with maintaining activities of living.	Ongoing	Individual interview Focus group discussion Additional individual interview
4	51-65	Female	P4 was a retired administrator. She was actively involved in a local Patient and Public Involvement (PPI) Forum and had contributed to several audits across NHS and private care home environments. She had experienced nursing care herself and also observed care delivered to her mother during a long illness.	6-12 months	Individual interview
5	65-80	Female	P5 was a retired Registered Nurse and qualified counsellor who had worked across an array of clinical contexts. She had experienced nursing care herself, in addition to observing care delivered to friends and family. She was actively involved in CQC	5-10 years	Individual interview

			inspections in the NHS and care home environments and pre-registration nurse education teaching and assessment.		
6	51-65	Female	P6 was a retired Registered Nurse, actively involved in some local voluntary agencies. She had experienced nursing care herself and observed care delivered to her husband who had dementia.	6-12 months	Individual interview
7	36-50	Female	P7 was currently working as a Registered Nurse in a local NHS trust, with experience from other regional trusts and agency work in care homes. She had experienced several episodes of nursing care and also observed care delivered to close family members.	0-3 months	Individual interview Additional individual interview
8	51-65	Female	P8 was a recently retired administrator who had some limited experience as a care support worker. She was actively involved in a local PPI forum in a role to provide insight from the lay perspective. Her experiences of nursing care arose from observing care delivered to her husband who had dementia and who currently resided in a care home.	Ongoing	Individual interview
9	51-65	Female	P9 was a former Registered Mental Health Nurse who no longer worked in care. She was a post graduate student, engaging in research. Her nursing care experiences were based on observations of care delivered to family members and her partner, who had a chronic illness. She was also involved in	Ongoing	Individual interview

			contributing to pre-registration nurse education teaching and assessment.		
10	65-80	Male	P10 was a retired factory worker who had experienced nursing care across a range of contexts due to ongoing health issues that had emerged in the past 5 years. He had also recently experienced orthopaedic surgery following a traumatic fracture resulting from a fall.	0-3 months	Individual interview Additional individual interview
11	65-80	Female	P11 was retired from voluntary work and was actively involved in delivering education to under graduate student nurses to share her experiences. These experiences had arisen through her observations of the care delivered to her husband who had dementia and had died some years previously.	2-5 years	Individual interview Focus group discussion

As identified in Table 3 above, the final sample comprised nine females and two males. One participant was in the 36-50 age range, five were in the 51-65 age range, four were in the 65-80 age range and one was in the 80 plus age range. In terms of time elapsed since the participants experience of care, three were experiencing ongoing care, two had experienced care in the previous three months, one in the previous three to six months, two in the previous six to twelve months, two in the previous two to five years and one in the last five to ten years. Commensurate with their positions as members of the university 'Service User and Carer' group, some had previous experience in a health care professional role, some were involved in formal teaching and assessment of undergraduate students and some were involved as lay members of local Public and Patient Involvement (PPI) forums. It is

acknowledged that there are potential limitations of the sample in terms of the issues identified above, an issue that is explored further in section 6.7. However, what was evident through data collection was that these issues had, in fact, positioned participants with a high level of preparedness to reflect on, and articulate, their perceptions of compassion. In particular, the length of time elapsed since the care experience had occurred did not seem to have any impact on recall. Rather, participants were able to discuss their care experiences with immense detail and clarity, thus reflecting the significance that they attached to experiencing compassion as an important aspect of nursing care. Any potential limitations of the sample were, therefore, far outweighed by the rich data that was generated as a result of the participants' insight into the care experiences that they had encountered.

4.4 Collecting the Data

4.4.1 Conducting Individual Interviews

The initial method of data collection was via a series of eleven in depth individual interviews. Individual interviews were semi structured and supported by a flexible interview topic guide to aid focus, which was based on broad themes underpinning the primary research question and objectives (Corbin and Strauss, 2008) (Appendix 13). This topic guide was a useful aide memoire, directing the focus of the interview to ensure the primary research question and objectives were addressed (Birks and Mills, 2011), even in circumstances where participants had a tendency to stray into the realms of general conversation. This approach provided a forum for participants to more freely discuss their experiences (Ritchie and Lewis, 2003) and articulate their perceptions of compassion in the context of nursing.

Throughout data collection, a conversational style was adopted in order to develop a rapport with the participant and encourage in depth discussion (Miller and Glasner, 2016). My primary role was to listen, remaining attuned and theoretically sensitive to the participant's story (Birks and Mills, 2011). However, in order to facilitate this, excellent levels of listening, memory and curiosity, coupled with the ability to sustain an effective rapport with the participant was required (Charmaz, 2006). Over the course of interviews, I became aware of my own developing expertise and found myself moving away from the semi structured approach towards a more unstructured approach, which is regarded as the most effective means to obtain the richest data (Corbin and Strauss, 2008). This was as a result of my personal development as an interviewer, and increasing levels of confidence to allow the participant to assume control of the interview and allow their narrative to unfold.

A primary question synonymous with the research question was utilised as the impetus for the interview:

Can you tell me what you think compassion involves and give examples of how your experiences of nursing care have contributed to your understanding of this?

The purpose of this open question was to stimulate discussion and allow participants the opportunity to freely articulate their perceptions of compassion. For many participants, the primary question was sufficient to inspire detailed discussion, which considered the broader themes of the interview guide. In these circumstances, simple probes to encourage participants to elaborate and clarify discussion points were adequate (Figure 7).

Figure 7: Example Probing Techniques

“That’s an interesting point...can you tell me more about that?”
“When you were discussing...can you tell me how that made you feel?”
“You mentioned earlier that...can you explore that in a little more detail?”
“You stated that...can you explain what you meant by that?”
“You said that...how did that affect you?”

For other participants, it was necessary to draw upon the interview guide to stimulate wider discussion. Assuming this flexible approach resulted in a series of unique interviews, all of which yielded a wide array of data. Adopting a flexible interview approach is necessary to facilitate a discourse between researcher and participant, and an essential component of gathering rich data (Mishler, 1986). Grounded theory interviews should be dynamic, exploratory and invite participant description and reflection. The role of the researcher in this process is innocuous, allowing participants the opportunity to freely share their stories (Charmaz, 2006).

Prior to commencing each interview, the purpose of the research was revisited, the participant was invited to ask further questions and ongoing consent was obtained (DH, 2005 d; ESRC, 2010). Addressing such issues in the introductory phase of the interview is good practice and an important strategy to maintain effective and ethical research relationships (Maltby *et al.*, 2010). My intent was to use this introductory phase as an ice breaking exercise, thereby enabling the participant to feel more at ease and engage more effectively with the interview. I was also mindful of ensuring the participant’s ongoing consent to partake in the research, an essential component

of ethical research practice (Holloway and Wheeler, 2002). Throughout the interviews, high levels of concentration were maintained to seek clarification of specific points and encourage further reflection on the participant's experiences (Ritchie and Lewis, 2003).

As previously discussed, probing techniques guided the participant to elaborate or revisit discussion points, resulting in an in depth exploration of the participant's experiences and perceptions of their subjective realities of compassion in nursing. Whiting (2008) emphasises the value of using probing techniques to gain more insight into the participant's experience and generate a fuller understanding of the phenomenon under investigation. Skilled interviewers implement strategies to delve beneath the surface of ordinary conversation to seek enhanced meaning and insight, resulting in what is regarded as an interpretive reconstruction of participant perceptions (Charmaz, 2006).

4.4.2 Location of the Interviews

Telephone contact was made with participants to arrange a mutually convenient date, time and venue to conduct the interview. This approach enables participants to feel more at ease and supports free articulation of their stories (Clarke, 2006). The aim of the initial telephone contact was, primarily, to negotiate when and where the interview would occur, but also to establish an introductory relationship between myself and the participant to engender a sense of equality and trust. Early establishment of a positive relationship between the researcher and participant is vital, to ensure they feel able to share their inner most thoughts, feelings and experiences, hence facilitating the collection of richer data (Walker, 2011).

Some participants opted to be interviewed in their own home, whilst others opted to be interviewed in the university setting. There were some slight differences evident between interview locations, characterised by the length of time taken to complete the interview. Interviews conducted in the university setting were noted to be of shorter duration than those in the participant's own home, reflexion on the potential reasons for this is presented later in the chapter. The shortest interview duration was in the university setting lasting thirty minutes, whilst the longest was in a participant's own home lasting one hour thirty-two minutes. On average, interviews lasted for forty-nine minutes.

4.4.3 Conducting the Focus Group Discussion

Eleven individual interviews led to the development of a range of emergent tentative categories through data analysis. At this point, data analysis did not seem to be uncovering any new knowledge, and there was a sense that theoretical saturation was approaching (Charmaz, 2014). Therefore, the next planned phase of data collection was implemented. This involved conducting a focus group discussion, with a group of participants who had the potential to provide further explication and elaboration of the emerging theory arising from the data so far (Strauss and Corbin, 1990; Lambert and Loiselle, 2005; Bryman, 2008; Birks and Mills, 2011). All these participants had been individually interviewed previously, and their data was noted to be rich in relation to the tentative categories developed to date.

The aim of the focus group discussion was for participants to elaborate on the tentative categories, and also to facilitate their contribution to the co-construction of the emerging propositional grounded theory; a notion commensurate with the principles of constructivist grounded theory (Charmaz, 2006, 2014). A decision was

taken to use a small group of participants. Smaller groups enable the researcher to maintain control of group dynamics and elicit meaningful participant interaction, particularly when complex issues are being discussed (Redmond and Curtis, 2009). This decision arose from my awareness that the issues for discussion were complex, and that participants had a vast range of experiences to share. Although I had developed some tentative categories and identified some focused codes of potential significance, I was unable to fully assimilate the importance and fit of these at this stage. Participants were therefore theoretically sampled for their potential to provide further insight into these issues, as a result of analysis of their individual interviews. Participants 1, 2, 3, 6, 8 and 11 (Table 3, p152) were identified for inclusion in the focus group, and all initially agreed to participate. Table 4 below provides clarification of the rationale for specific participant selection.

Table 4: Overview of Focus Group Discussion Participants

Participant	Rationale for Selection
1	Selected for her wide range of nursing care experiences and because she was the initial 'gatekeeper' to sampling and data collection. Her data had revealed a wide range of initial codes which had been instrumental in contributing to the development of the emerging tentative categories. The codes emerging from her data were strongly focused on personal qualities, professional skills, biological influences, reciprocity and person centred approaches to care.
2	Selected for his positive experience of compassion which was rated as 9 and also because this was one of only two male participants involved in the research. Data analysis of the interview identified a strong focus on care environments in relation to resources and workloads.
3	Selected for her positive experience rated at a level of 8. This participant's data uncovered a strong focus on contextual/structural factors, specifically in relation to technology, documentation and time. Her data also revealed a strong emphasis on the importance of personhood.
6	Selected as she was a retired Registered Nurse to provide an alternative perspective from both a care giver and care recipient point of view. Her data had uncovered initial codes strongly relating

	to the importance of the person, in addition to codes associated with personal qualities, professional skills, care environments and workload/staffing/increasing use of technology.
8	Selected due to negative experiences which were rated at a level of 2. The aim was to compare the initial codes that had emerged from her negative experience with initial codes emerging from other participants' positive experiences. These initial codes related to personal qualities, professional skills, biological influences, care environments and person centred approaches.
11	Selected for her negative experience of compassion which had been rated as 3. Analysis of her individual interview suggested that she may be able to offer further saturation of the categories related to personal qualities, professional skills and socialisation/nurturing strategies which were noted to be strong themes in her data.

To enable participants to contribute to the co-construction of the propositional grounded theory, I was aware that I needed to devise a means of achieving this and use an appropriate strategy to engage them in meaningful discussion. At the same time, I also wanted to obtain further elaboration of the tentative categories developed to date, and explore the potential existence of any additional new categories.

Charmaz (2014) suggests using a member checking strategy to structure the focus group discussion, outlining two exemplars of innovative methods used by other researchers to achieve this (Alasuutari, 1996; Albas and Albas, 2004, cited in Charmaz, 2014).

The first member checking method involves presenting participants with an outline of the tentative categories constructed from data analysis and engaging in subsequent discussion to explore the fit of these with each participant's experience. The second involves using raw data to generate discussion and instigate further insight, by implicitly exploring the emergent categories to elicit data that participants may have overlooked. Both strategies are underpinned by theoretical sampling processes,

which aim to explicate the emerging theory (Charmaz, 2014). I implemented an approach which included aspects of both of these member checking strategies, with the aim to enhance trustworthiness of the research by triangulating data (Creswell, 2005; Bruce, 2007) to establish the emerging fit (Glaser and Strauss, 1967) of the findings with a small group of participants. This facilitated ‘crystallisation’ (Richardson, 1991) and ‘comprehensiveness’ (Mays and Pope, 2000), affording clarity to the data through corroboration of complementary perspectives across participants, thus providing scope to further refine the emerging theory.

A participant focus group discussion guide was developed (Appendix 14), which incorporated words and quotations taken directly from participant data. These were assimilated into five discussion points to represent the tentative categories developed from individual interviews to date. The aim was to use the discussion points to guide a structured exploration within the focus group; a recognised and effective data collection strategy (Morgan, 1997). This structured approach aimed to explicate the grounded theory and advance theoretical saturation (Glaser and Strauss, 1967). It provided participants with the opportunity to engage in discussion, thereby enabling them to contribute to the co-construction of the tentative emerging categories and consider the relevance and fit of these to their individual experiences and perceptions (Charmaz, 2000; Bryman, 2008).

The focus group was scheduled for a mutually convenient date and time. However, as is often the case with focus groups, challenges arose in relation to participant withdrawal (Redmond and Curtis, 2009). Two participants (P1 and P6) withdrew on

the day preceding the focus group due to ongoing ill health, and one participant (P8) failed to attend on the day. As a result, only three participants (P2, P3 and P11) were involved in the focus group discussion. Although I had some concerns about this, I made the decision to continue as planned. This proved to be an appropriate course of action as the focus group led to an array of rich and meaningful data, as the discussion that ensued between the three participants was extremely interactive. Discussion in a small group situation afforded the opportunity for the exploration of a range of perspectives, arising from both positive and negative points of view, which was instrumental in elaborating the emerging grounded theory.

The focus group discussion involved three distinct phases incorporating a pre discussion phase, a main discussion phase and a post discussion phase. The pre discussion phase introduced and clarified the purpose of the focus group, gained ongoing informed written consent and provided an opportunity for participants to introduce themselves to each other in an ice breaking activity. An array of skills were required to facilitate an effective group discussion and key to this, was the ability to put participants at ease and engage them in meaningful dialogue (Redmond and Curtis, 2009). During the main discussion phase, reflective listening and appropriate probing questioning (Fern, 2001) was implemented as a means to encourage participant interaction and clarify the relevance and fit of the five discussion points to individual perceptions. Participants were also encouraged to annotate their copy of the discussion guide as they deemed appropriate. A wide range of interpersonal skills and an attentive approach was required to facilitate the

group and maintain focus on the discussion points, which is essential for successful participant interaction (Stewart, Shamdasani and Rook, 2007).

The post discussion phase afforded participants the opportunity to ask questions and contribute further data, providing a vital opportunity to stimulate additional discussion (Kruger and Casey, 2000). Throughout the focus group, a research active colleague was present to make observations and record notes in a supplementary role, a strategy to support the group moderator endorsed by Rothwell, Anderson and Botkin (2016). This strategy proved to be of high utility, as the intense nature of moderating the group discussion and maintaining high levels of concentration inhibited my capacity to take additional notes. Birks and Mills (2011) identify the challenges of facilitating focus groups in relation to maintaining the focus of discussion and following up on emerging theoretical leads, encouraging researchers to be mindful of this and suggesting supporting strategies to address this. The focus group discussion lasted for a period of two and a half hours, inclusive of a thirty-minute refreshment break at the midpoint. Kruger and Casey (2000) suggest that two hours should be the maximum duration of a focus group, as participants generally reach their attention limits by this point. This was noted to be the case due to the intensive interactive dialogue that ensued between the three participants. By the end of the discussion, all participants had contributed immensely, and a vast range of rich and meaningful data had been elicited. The discussion generated further insight into individual perceptions of compassion and afforded participants the opportunity to compare and contrast their nursing care experiences.

Discussion between the participants often raised challenges to individual perceptions, which facilitated reflection and a deeper exploration of some of the issues identified from previous interviews. This was influential in the process of elaborating the tentative categories developed to this point, and further highlighted the significance of previously identified codes. What was also clear, was a deeper level of discussion in relation to issues not fully explored or understood previously. Uncovering these new insights was central to progressing analysis of the research findings. The focus group led to further elaboration of the tentative categories, established the existence and significance of a core category, enhanced my understanding of the emerging theory and provided further clarity to the findings. This was influential in contributing to the construction of the final propositional grounded theory that is presented in Chapter 6.

4.4.4 Conducting Additional Individual Interviews

Following the focus group discussion, it was evident that the grounded theory emerging from my research was moving toward a substantive construction of participant perceptions. Theoretical saturation (Glaser and Strauss, 1967) of the categories had developed significantly by this point, however it was apparent that the emerging core category required some further elaboration. This was achieved in the first instance by implementing a strategy to advance the level of data analysis by revisiting previously coded interviews (Charmaz, 2006). However, in order to elaborate the category further, an informed decision was taken to return to theoretical sampling and conduct additional interviews.

Charmaz (2014) reiterates the ongoing and cyclical nature of data collection and analysis, highlighting the flexibility of constructivist grounded theory to facilitate

this. The primary purpose of theoretical sampling is to support data collection, which maximises opportunities to develop the grounded theory (Corbin and Strauss, 2015). Therefore, three further individual interviews were conducted with participants who had already been involved in previous data collection, and whose data suggested that they had potential to elaborate the emerging grounded theory (Appendix 12). Previous analysis of the data collected from these three specific participants (P3, P7, P10) suggested that they had the potential to elaborate the emerging core category, due to a strong sense that they perceived aspects of care related to person and human focused approaches to be of high significance. Overall, fifteen episodes of data collection events ensued throughout the research process (Bruce, 2007).

4.4.5 Audio Recording the Data

With participant consent, all phases of data collection were recorded in order to obtain a permanent record (Whiting, 2008). However, I was cognisant of the potential impact of the audio recording device on participant behaviours to provide socially desirable responses (Patterson, 1994). To minimise the potential impact of this, I drew upon my existing expertise to develop a positive interpersonal relationship with participants to facilitate a relaxed and conversational style of discussion. Although participants gave consent and were aware that the interview was being recorded, the audio device was located in an unobtrusive position. Al-Yateem (2012) supports this strategy, indicating that although the participant needs to be aware that the interview is being recorded, it is essential for researchers to minimise any visual indication of its presence. This approach was effective in promoting enhanced participant engagement with the interview process.

4.4.6 Transcribing the Data

As soon as was practicable after the initial interview, I personally transcribed the audio recording verbatim in order to achieve a sense of immersion in this early data. Undertaking timely personal transcription of research data is an effective strategy for early data analysis, as the process can facilitate the researcher becoming immersed in the data (Whiting, 2008; Balls, 2009). However, the complexities of transcription were evident in relation to issues such as representing conversational pauses, specific voice intonation and the inherent difficulty of achieving an accurate representation of the spoken word (Sandelowski, 1994; Balls, 2009). Whiting (2008) identifies that accurately capturing the participant's words is challenging and thus, the audio recording may need to be played back several times, further contributing to the time to complete the activity.

Transcribing the initial interview proved to be onerous and time consuming, and was impeded further by my limited typing skills; common challenges often reported by researchers (Byrne, 2001; Matheson, 2007). The initial transcription resulted in 9,633 words. Overall, individual interview transcriptions amounted to 81,570 words, with the focus group adding a further 12,654 words. This resulted in a total of 94,224 words across all transcriptions, giving an indication of the time required to complete the transcribing activity. Using voice recognition technology was considered as a means to simplify and expedite the transcription process. However, reported issues from other researchers relating to software inconsistencies and accessibility seemed to be counterproductive to this strategy (Anderson, 1998). Support from an independent transcriber was therefore sought.

The costly nature of employing independent transcribers is noted as a challenge by many researchers (Byrne, 2001; Alcock and Iphofen, 2007). However, others are more pragmatic, suggesting that using the researcher to transcribe data is less cost effective and a more inappropriate use of time (Duffy, Ferguson and Watson, 2004). As it was essential to maintain progression in accordance with the timeline of my Gantt chart (Appendix 15), I concluded that spending hours transcribing audio interview data was a luxury I simply could not afford. Grounded theory methods dictate that data analysis needs to occur before further participants can be theoretically sampled (Charmaz, 2014). An independent transcriber was therefore engaged to support and expedite this process, but not utilised in all instances. Rather, an informed decision was taken to periodically transcribe some interviews personally as a means to maintain ongoing immersion in the data.

4.5 Analysing the Data

4.5.1 Implementing Constant Comparative Analysis

Constant comparative analysis was implemented throughout all phases of data analysis. As analysis progressed, I moved between earlier and later transcripts to advance the level of coding, seeking to clarify codes and tentative categories previously identified and uncover those which may have been difficult to discern previously (Charmaz, 2014). As more data was collected, this process was conducive to effectively implementing a constant comparative analytical method. This involved comparing data with data, incident with incident and category with category, across participant data from individual interviews and the focus group discussion (Glaser and Strauss, 1967). Drawing upon data that illustrated both positive and negative participant perceptions of compassion, was essential throughout this comparative

process to uncover variation. This strategy is advocated by Charmaz (2006), as a means to develop researcher interpretations and support construction of the emerging grounded theory.

This ongoing and dynamic process facilitated the development of enhanced abstract and theoretical levels of thinking, which is indicative of analytical advancement (Charmaz, 2014). Reflexivity was key to this process as I constantly pondered on the data, contemplating the wider picture of what the data potentially represented from a more theoretical perspective. The more I interacted with the data and made comparisons, the more my analytical thinking advanced. Constant comparative analysis was maintained throughout advancing data analysis, at all levels of coding. It is precisely this iterative process which led to the construction of the propositional grounded theory (Birks and Mills, 2011).

4.5.2 Undertaking Initial Coding

Preliminary data analysis was conducted by a process of initial coding (Charmaz, 2006, 2014). Initial coding was completed with all transcripts before moving on to further data collection, thereby facilitating theoretical sampling. Transcripts were formatted into documents with wide margins, and printed to allow manual annotation. Applying the coding principles advocated by Charmaz (2014), I worked quickly through the data to apply line by line codes to the transcription. A reflexive approach informed this process, as I strived to elicit what was occurring in the data, drawing upon gerunds and ‘in vivo’ codes to fragment the data into its component parts to represent this (Glaser, 1978). Initial coding of the initial interview proved to be time consuming and challenging at times, as I was unsure that I was applying the

technique correctly. I persevered and, as a result, developed an increasing level of expertise as data analysis progressed throughout the research process.

A supplementary strategy was utilised to give further credence to the initial coding process. This involved engaging my supervisory team and a research active colleague to perform blind coding on two transcripts, a valuable strategy to cross reference emerging interpretations between researchers (Barbour, 2001). Transcripts of the initial interview, and an interview at the mid data collection point, were selected for this purpose. These blind coding reviews corroborated initial codes identified at this point in analysis, providing affirmation that an accurate interpretation of the data was being elicited. Machin, Machin and Pearson (2012) and Cooney (2011) utilised a similar blind coding strategy to confirm their emergent findings, although this was implemented in the final stages of data analysis. However, I was keen to apply this strategy at an earlier stage of the research process to provide personal reassurance that my analysis was evolving as would be expected, and also to affirm that the initial codes I had constructed from the data resonated with the interpretations of other expert researchers.

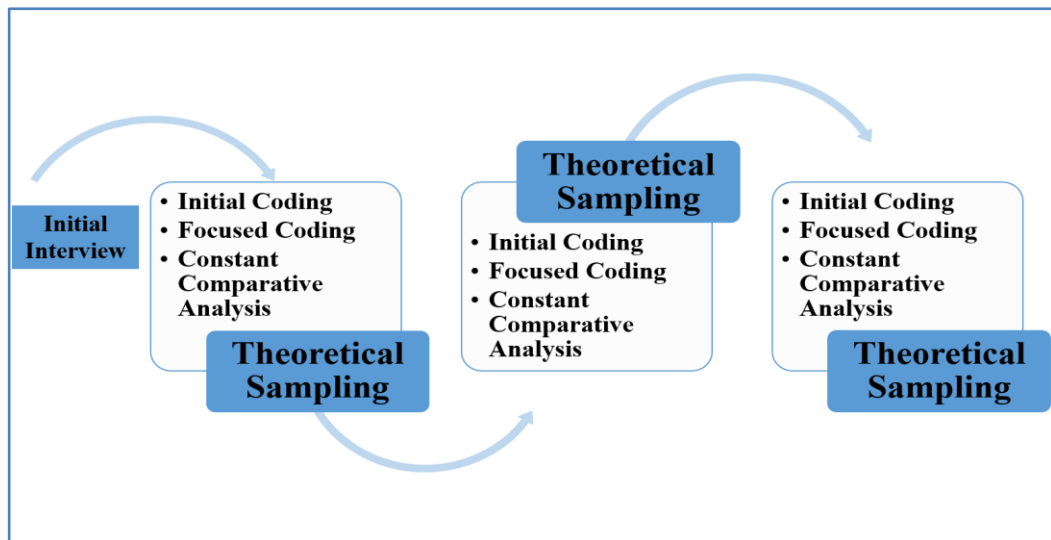
Initial coding was conducted with all transcripts to identify emerging codes. This facilitated the opportunity to make comparisons within and across transcripts, seeking to uncover similarities, differences and variations. Constant comparative analysis was instrumental in facilitating the analytical process as data was concurrently collected and analysed (Glaser and Strauss, 1967). An extract from the data is presented in Appendix 16 to provide an exemplar of initial coding. This is

revisited throughout the succeeding data analysis discussion to demonstrate advancing levels of coding and the implementation of the analytical process that was undertaken.

4.5.3 Undertaking Focused Coding

Following initial coding, focused coding was conducted with all transcripts (Charmaz, 2006, 2014). Although the phases of coding are presented in a sequential format for clarity, it is important to note that these phases were cyclical and implemented using a dynamic and iterative approach. To clarify this point, initial coding, followed by preliminary focused coding to group initial codes of the initial transcript together led to the development of tentative categories. This was followed by theoretical sampling to collect more data. Further initial coding was conducted with the new transcript and constant comparative analysis used to compare the data across transcripts. Focused coding ensued to further group initial codes together, further develop tentative categories and develop a foundation from which to build the emerging theory. This was followed up by further theoretical sampling and data collection to elaborate and refine the analysis, and so on. This cyclical process is illustrated in Figure 8.

Figure 8: Sampling, Data Collection and Data Analysis



This cyclical process of data analysis enhanced theoretical sensitivity as data collection and analysis advanced (Glaser and Strauss, 1967). This often involved returning to transcripts that had already been coded to uncover and explore issues that may have been implicit and not fully elicited previously (Charmaz, 2006). Sometimes, this resulted in identifying additional initial or focused codes, and refining or developing tentative categories. This iterative process ensued throughout the entire period of data collection, as I strived to make theoretical sense of the data and determine theoretical saturation. The dynamic, evolving and emergent approach to data analysis was a key strength of the grounded theory coding methods that were implemented. It enabled active interaction with the data, facilitating analytic immersion in the participant's experiences, and led to the development of a grounded theory that is derived directly from the data (Charmaz, 2000, 2014). A reflexive approach to advance analysis to a higher level of conceptualisation was integral to this process. The data extract exemplar of initial coding presented in Appendix 16

moves forward the analytical process to demonstrate advancing analysis through focused coding.

Charmaz (2014) suggests that some researchers may also opt to implement axial coding at this point. Axial coding is an analytical framework developed by Strauss and Corbin (1998) to facilitate organisation of the previously fragmented data into a coherent order by relating emerging codes to categories and explicating the links between these. The process requires the researcher to use a highly prescriptive framework to identify factors such as conditions, actions and consequences (Strauss and Corbin, 1998). Charmaz (2014) argues that this phase of coding is unnecessary and rather than develop the theory, the prescriptive nature of the framework can limit the researcher's vision and inhibit theory development. Glaser (1992) agrees with this point of view, stating that using a prescriptive framework can limit the analysis and result in the researcher 'forcing' the data.

Charmaz (2014) advises using a flexible approach to coding, whereby data analysis lends itself to an emergent, rather than a procedural process. I contemplated this, concluding that the highly prescriptive nature of the axial coding framework had immense potential to limit my ability to make sense of the data and encourage me to fit the data to the framework. This is reflective of the experience of Kendall (1999), who deduced that her analysis was impeded as a result of axial coding, as she was focused on completing the procedural framework, rather than seeing and understanding what the data revealed. I therefore made an informed decision to refrain from using axial coding, electing to maintain a reflexive approach to allow

knowledge and understanding to emerge and support construction of the grounded theory. This proved to be the right decision, as ongoing reflexion continued to be the significant factor contributing to enhanced theoretical sensitivity and theory construction (Charmaz, 2014).

4.5.4 Documenting Theoretical Memos

Documenting theoretical memos was a vital method to advance data analysis.

Reflexion was integral to this, and active engagement with the data led to ongoing contemplation to uncover what the data was revealing (Birks and Mills, 2011; Charmaz, 2014). After episodes of data analysis, theoretical memos were documented to formulate ideas and insights. These memos maintained a record of my ongoing internal reflexive analysis and were instrumental in enabling me to make sense of the data and support construction of the final propositional grounded theory (Lempert, 2007). I found myself making memos at unanticipated points during the research journey, often at times when I was not even actively engaging in the research process; for example, when driving to work, or waking in the night with an idea that provided me with unexpected insight.

Engaging in reflexion, and documenting my emerging ideas into theoretical memos to make sense of the data fully occupied my thoughts throughout the doctoral journey. This level of immersion in the analytical process is an activity that is considered to be essential, thus allowing the grounded theory to unfold (Stern, 2007). The data extract exemplar of initial and focused coding presented in Appendix 16 progresses the analysis to demonstrate theoretical memoing, providing insight into my emerging thoughts and ideas.

4.5.5 Drawing Theoretical Diagrams

Theoretical diagrams were used to provide a visual representation of the emerging theory, further advancing and developing ideas arising from theoretical memos (Charmaz, 2014). The diagrams were simple illustrations to represent my analysis of what was emerging from the data, rather than an attempt to use the structured techniques offered by Strauss and Corbin (1990) or Clarke (2005). Although diagramming techniques are not considered to be an essential requirement of constructivist grounded theory methods (Charmaz, 2014), using simple theoretical diagrams to represent my developing insights into the emerging theory was integral to my analytical development. The process of diagramming throughout data analysis provided a visual map, which evolved and developed to inform the final propositional grounded theory. The data extract exemplar presented in Appendix 16 is progressed further to demonstrate theoretical diagramming, illustrating analytical advancement.

4.5.6 Conducting Advanced Coding and Analysis

As data analysis advanced, a range of focused codes were identified and a series of theoretical memos and diagrams were documented. A theoretical sorting technique (Glaser, 1978) was subsequently implemented to make sense of this, which provided a platform for developing and refining theoretical links (Charmaz, 2014). This involved assimilating codes, extracts from the data, memos and diagrams into tentative categories, a strategy endorsed by Wiener (2007). The data extract exemplar presented in Appendix 16 is progressed further to illustrate advanced coding, building upon initial coding, focused coding, theoretical memoing and theoretical diagramming. This exemplar provides an overview of the entire data analysis process undertaken using the selected data extract.

The theoretical sorting stage was not an isolated event. Rather, it was a cyclical process, undergoing several iterations at various points throughout the research journey. A series of these iterations are presented in Appendix 17 to illustrate the evolving nature of this process. Theoretical sorting facilitated advancement of the level of my conceptualisation and provided an enhanced insight into the data. However, a temporary plateau was reached using this technique, so I concluded that it was essential to consider additional analytical methods to further advance the emerging data categories. I was faced with a range of focused codes, tentative categories, memos and diagrams, of which I needed to make more theoretical sense. Although I was aware that I was on the brink of finalising the data categories, I recognised that they were not yet fully developed. Using relevant grounded theory analytical processes, ongoing reflexivity and drawing on my developing theoretical sensitivity had led me to this higher stage of analysis, but further advancement was required.

To advance analysis, a mapping technique was used to outline key concepts emerging from the data, enhancing clarity and explicating links (Clarke, 2005). Drawing upon this mapping technique, concepts were assimilated into a ‘messy map’, applying reflexivity to ask questions of the data such as *what is happening?* *what are the participants conveying?* *what actions and processes are involved?* (Clarke, 2005). This process resulted in the development of a theoretical diagram and memo, advancing analysis to identify the data categories (Appendix 18). It supported progression towards what is termed the ‘eureka’ moment, which is said to be

essential in the journey towards advanced analysis and refinement of the grounded theory (Charmaz, 2014).

At this stage of analysis, I considered myself to be in a position to validate the emerging data categories. Further reflexion and contemplation facilitated the organisation of previously identified focused codes and tentative categories coherently, into a refined format. This was essential to elevate the findings from a descriptive level, to a more conceptually abstract level (Charmaz, 2000; Charmaz and Bryant, 2016). Some focused codes and tentative categories were organised into major categories, some were identified as being properties of these and some were subsumed into this newly revised format. Although not an essential requirement of constructivist grounded theory, a core category was clearly evident. The data categories identified at this point were assimilated into a diagram to represent participant perceptions of compassion in the context of nursing, which is presented in Chapter 6.

4.5.7 Constructing the Grounded Theory

Reflexivity ensued in a more detailed consideration of the data categories, to elicit at a more conceptual level, what participants fundamentally perceived compassion to involve. Dey (2007, p168) highlights that categories are a means to provide a descriptive overview of the findings which are ‘grounded’ in the data, providing the ‘theoretical bones’ which the researcher seeks to ‘flesh out’ as reflexivity advances at a more conceptual level to construct the grounded theory. In essence, the goal is to construct a grounded theory that is founded on key concepts emerging from the categories and which clarifies how they relate to one another (Gibson and Hartman, 2014).

Reflexivity to consider the underpinning theoretical influences of symbolic interactionism (Blumer, 1969) and social constructionism (Berger and Luckam, 1966; Burr, 1996; Gergen, 1999) progressed conceptualisation of the data categories. This ensued in identifying key factors of significance, which were drawn upon to implement a conceptual mapping activity (Appendix 19) to advance the analytical process further (Clarke, 2005). This mapping activity involved a process of theorising to contemplate what was emerging from the data categories of the research findings, elevating the findings towards a higher level of conceptualisation and maintaining analytical momentum to move the analysis from a descriptive, to a more theoretical position (Charmaz, 2014; Charmaz and Bryant, 2016).

Conceptual mapping provided a means to advance the data categories and was instrumental in the subsequent construction of the propositional grounded theory. Charmaz (2006) states that a robust grounded theory offers an abstract and interpretive understanding of the phenomenon under investigation, representing multiple realities that emerge through subjective social experiences. This is what the propositional grounded theory that is presented in Chapter 6 has achieved, a multidimensional abstract representation of participant perceptions of compassion within the context of nursing.

4.5.8 Developing Theoretical Sensitivity

Reflexivity was a key component of my research journey and integral to supporting development of theoretical sensitivity during data analysis (Glaser and Strauss, 1967). Reflexivity involved implementing a systematic cognitive appraisal of the data to gain insight and understanding, supporting the development of succeeding research activity and outcomes, particularly in relation to theoretical sampling and

advancing analysis. Reflexivity was key to understanding and interpreting the concepts emerging from the research data, and of vital importance in constructing the grounded theory (Birks and Mills, 2011).

Following each episode of data collection, time was taken to reflexively contemplate the experience. During the initial stages of data collection, reflexive activity was often focused on operational aspects of the episode itself, in terms of what had gone well, what could be improved and my overall sense of the quality of the data generated. As the research progressed and confidence developed in my interview expertise, reflexive activity increasingly focused on the data as initial codes, focused codes, tentative categories and the potential links between these emerged. Prior to transcription, audio recordings were replayed to identify primary key concepts and initial thoughts were documented in memos, to ponder early interpretations of what was emerging from the data. The process of scanning audio recordings for emerging concepts was a preliminary level of analysis, providing an overview of the data and enhancing my level of theoretical sensitivity as I developed an awareness of what the data was revealing (Wainwright, 1994).

To achieve theoretical sensitivity, detailed data analysis was conducted using the initial, focused and advanced coding techniques discussed previously. Constant comparative analysis was utilised to enhance this further, by moving between data collection and data analysis to compare data with data, code with code, category with category (Charmaz, 2006). This process of theorising supported identification of fundamental concepts and facilitated an advancing level of abstraction, enabling me

to remain open to the possibilities and connections that were emerging from the data (Charmaz, 2014). As mentioned earlier, implementing a reflexive approach to raise my level of theoretical sensitivity resulted in an overwhelming and all-consuming process, at times. This was instrumental in enhancing my understanding and insight into what the data was uncovering, and vital to advancing the level of critical analysis and abstraction that was required to construct the propositional grounded theory (Stern, 2007; Urquhart, 2013).

Although I possessed an existing level of sensitivity due to the embodiment (Clarke, 2005) arising from my personal and professional experience, this was enhanced during the focused phase of the literature review that was implemented following data analysis (Strauss and Corbin, 1990). This elevated my level of theoretical sensitivity, as I acknowledged that ‘all is data’ throughout the analytical process to facilitate insight into what the data was revealing, transcend description and establish abstract concepts of fit and relevance to participant perceptions (Glaser, 2002).

4.5.9 Reaching Theoretical Saturation

As the research progressed, a reflexive approach was taken to consider the concept of theoretical saturation and identify when it was appropriate to discontinue data collection (Glaser and Strauss, 1967; Charmaz, 2014). Ongoing reflexivity was implemented throughout all stages of data analysis and was instrumental in facilitating theoretical sampling and data collection, as I strived to elaborate the emerging categories of the grounded theory and determine them to be conceptually complete (Strauss and Corbin, 1990). During this iterative and analytical process, as new codes and insights failed to emerge and the categories were developed and refined to construct a robust grounded theory, informed assumptions were made that

theoretical saturation, in terms of ‘sufficiency’ and ‘adequacy’ had been achieved (Dey, 1999; Bowen, 2008). This process was facilitated by appropriate theoretical sampling of participants who had the potential to elaborate and refine the emerging grounded theory (Corbin and Strauss, 2015).

Reaching theoretical saturation involved a process of conceptualisation, which was instrumental in facilitating the generation of the grounded theory (Glaser, 2001). It was founded on raising the level of analytical abstraction to develop a grounded theory which preserved the integrity of the data, whilst simultaneously making sense of it (Charmaz, 2014). It was this ongoing process of striving to elaborate the categories and conceptually raise my level of analytical abstraction to construct the final propositional grounded theory, which supported the conclusion that saturation had been reached. At the point where my interpretations of the data had been sufficiently saturated (Dey, 2007) and no new insights were emerging, data collection was discontinued (Cutcliffe and McKenna, 2002). Glaser and Strauss (1967) state that a grounded theory which has achieved theoretical saturation during the active research phase is merely a foundation from which to suggest theory, providing an opportunity for further research into the phenomenon under investigation. I would argue that my grounded theory has achieved precisely this, a comprehensive and robust insight into individual perceptions of compassion in nursing, which provides an original contribution to knowledge and a platform from which opportunities for further research can be initiated.

4.6 Reflexivity: The Research Journey

As discussed earlier, reflexivity was a key part of my research journey, and an activity I engaged in throughout. Throughout the research, a reflexive approach was taken to contemplate a wide range of issues, striving to ensure the trustworthiness and credibility of the study (Bonner, 2001; Charmaz, 2014). Examples of this reflexive activity, specifically related to the target sample population, selection of the initial participant and the interview process, are outlined in the following section.

4.6.1 The Target Sample Population

Engaging in reflexivity highlighted some limitations of the target sample population, particularly in relation to their motivation to be involved in the ‘Service User and Carer Group’ in the first instance, and the potential impact of this on individual bias. Individuals are known to have complex reasons for becoming involved in formal initiatives to share their narratives with others, and are often driven by positive or negative personal experiences (Cotterell *et al.*, 2010). This implies that individuals may be driven by an underlying, and ulterior, motive. However, it is these specific positive and negative experiences that make such individuals a valuable and rich source of information, placing them in a unique position to discern a variety of issues relating to nursing care practice (Altree, 2001). It is claimed that relational issues of nursing care, such as experiences of compassion, can only be fundamentally elicited through exploration of individual perceptions (The Kings Fund, 2011; CQC, 2014). It therefore seemed appropriate to target a group of individuals with extensive experience of care, to explore compassion in nursing within the context of my research.

The most appropriate research participants are considered to be individuals who have experience of the phenomenon under investigation, are willing to participate in the research and who are sufficiently reflective to engage in discussion about their experiences (Spradley, 1979; Morse, 1991). The target sample population possessed these characteristics, positioning them as an appropriate sample to provide rich data to inform the research. The research did not seek to gain a representative perspective of compassion in the context of nursing. Rather, it sought to gain an in depth understanding and insight from a defined sample of participants, which may have resonance with similar groups of individuals; commensurate with constructivist grounded theory approaches (Charmaz, 2014).

Reflexivity enabled me to acknowledge that in all research practice, researchers must accept the potential limitations of accessing any specific defined sample population, due to the exclusion of other potential participants who may also have rich experiences to share (Tuckett, 2004). Acknowledging this, a decision was therefore taken to maintain ongoing reflexivity, ensuring that the rationale for sampling decisions were documented (Appendix 12) to maintain a clear audit trail and thus, facilitate trustworthiness (Neill, 2006). Arguably, accessing a defined target sample population of individuals with diverse experiences enhanced the scope and breadth of the data (Charmaz, 2014), enabling understanding of compassion to be developed in a more generic sense and supporting resonance with others.

4.6.2 Selecting the Initial Participant

Selecting the initial participant for interview required a high degree of reflexivity, in order to ensure that an appropriate ‘gatekeeper’ was selected (Cutcliffe, 2000). A sense of uncertainty unfolded at this stage of the research, as I was unclear which

prospective participant was the most appropriate to sample. The importance of reflexivity was apparent, as a vital means to support decision making processes (Fontana, 2004; Jooton, McGhee and Marland, 2009) and provide a rigorous foundation to maintain a clear audit trail (Lincoln and Guba, 1985; Primeau, 2003; Parahoo, 2006; Cooney, 2011).

In the early stages of my research I had commenced a journal to document key events in the research journey. Initially, the journal had been used to document anxieties, fears and concerns and served as a means to record research progress. This is reflective of the experiences of Clarke (2009), who also identified that the journal merely provided a means to record personal anxieties and completion of key research tasks. Although the use of a research journal to document and clarify personal thoughts, feelings and progress is supported, the utility of documenting analytical reflections to assist in the development of conceptual understanding is of paramount importance (Koch, 1994; Jasper, 2005). Utilising a journal to reflect on research is a strategy endorsed by grounded theory methods. The journal encourages reflexivity to develop theoretical memos and record methodological and analytical decisions, subsequently enhancing the audit trail (Strauss and Corbin, 1998; Corbin and Strauss, 2008). This more analytical strategy was adopted, and an enhanced reflexive approach taken to analyse the sample population matrix. My emerging conceptual thinking was documented in the journal (Appendix 20), and this was pivotal in developing a rationale to underpin selection of the initial participant for interview. Implementing this reflexive approach proved to be an ongoing requirement and was

instrumental in facilitating my progression through the complex, and at times, challenging doctoral journey.

4.6.3 The Interview Process

Implementation of the interview process led me to reflexively consider some key issues of significance. This reflexive activity specifically focused on my existing professional communication skills, in addition to the influence of the location of the individual interviews. Bulpitt and Martin (2010) claim that the skills required for research interviews are often closely related to the skills utilised by professionals in the course of their everyday work. However, although nurses often possess enhanced communication skills, it is essential to be reflexive about how they are applied to the research arena, in order to minimise the potential for interviewer bias (Duffy, Ferguson and Watson, 2004).

The notion that nurses are effective communicators led me to reflect on my expertise as a research interviewer in contrast to my professional background as a registrant, and consider the need to be reflexive during interviews in my dual researcher and professional nursing role. I therefore remained mindful of my potential to influence the data, drawing upon existing communication and interpersonal skills to avoid questions which may be considered as leading. These skills proved to be extremely important throughout data collection. As data collection advanced I moved through a transformational process, reflexively embracing the challenges of research as an opportunity for personal growth and development (Holligan, 2005; Mays and Smith, 2009). This transformative process enabled me to move from a position of uncertainty to one of confidence in my interview expertise, through essential

reflexive activity to nurture my evolving skills as a researcher (Jarvis, 2006; Callery, Werthner and Trudel, 2012; Baillie, 2014).

It is vital for researchers to acknowledge that the environment can influence data collection (Walker, 2011). In this research, the location of individual interviews appeared to have some importance, as interviews conducted in the participant's own home were noted to be of longer duration than those conducted in the university setting. Assuming a reflexive approach to this, I came to realise that in all cases where participants were interviewed in their own home, the activity appeared to offer a means of social contact. Nagy *et al.* (2010) highlight that researchers often identify this to be the case, and suggest that as mutually beneficial relationships are an integral part of ethical research practice, researchers must embrace this in order to ensure the principle of beneficence. In promoting ethical principles, I therefore made an active effort to address participant's social needs to whatever extent I was able, within the time I had available.

In contrast to this, the duration of interviews in the university setting were noted to be marginally shorter. Reflexivity on this issue led me to consider the influence of potential power issues arising from the academic environment. Research interviews are undoubtedly impacted by implicit influences of power between researcher and participant. Power is considered to be present at a dynamic level in all human interactions (Sandelowski, 1991) and in all environments where formal research interviews occur (Elwood and Martin, 2000). It was therefore essential to consider that it may also be present within an environment perceived to be my primary

domain as the researcher (Nunkoosing, 2005). It was important to remain mindful of this, to ensure that appropriate social conventions and interactions were implemented to assist participants to feel at ease throughout the interview. Strategies to decrease participant perceptions of researcher power were therefore implemented. This included introducing myself by my first name and addressing participants by their preferred name, thus facilitating a sense of equality in the interviewer and interviewee relationship (Fern, 2001). These approaches were of high utility in supporting participants to freely articulate their experiences.

4.7 Establishing Trustworthiness

Interpretive research methodologies do not strive to achieve validity or reliability, rather they strive to establish trustworthiness. Beck (1993) purports that trustworthiness in qualitative research is exemplified by rigour, specifically in relation to the credibility, auditability and fittingness of the research findings. In the grounded theory research arena, there is much debate regarding the way in which researchers can demonstrate trustworthiness in their research. Glaser and Strauss (1967) discuss the principles of fit and making sense of the findings, as a means to judge the adequacy of a grounded theory. Strauss and Corbin (1990, 1998) suggest that aspects of fit, understanding, generality and control are quality indicators of key importance to determine trustworthiness. Elliot and Lazenbatt (2005) offer a more simplistic view, suggesting that authentic and transparent implementation of the research methods is the primary means to determine trustworthiness in a grounded theory study.

Charmaz (2014) identifies that evaluating the quality of a grounded theory study involves aspects that encompass elements of all of these propositions, purporting that trustworthiness in constructivist grounded theory research is achieved by demonstrating credibility, originality, resonance and usefulness. To establish credibility, researchers are required to present a comprehensive and transparent account of the implementation of research methods, data collection and analytical strategies. To establish originality, researchers are required to demonstrate new and innovative insights into the topic area, eliciting social and theoretical significance to further develop existing knowledge. To establish resonance, researchers are required to provide a comprehensive representation of the findings, which makes sense to others and enables a level of generality to similar individuals in similar situations. To establish usefulness, researchers are required to develop a grounded theory that has utility in the everyday social world, identifies implications that can improve future practice and which lays the foundations for further research opportunities (Charmaz, 2014). In order to demonstrate trustworthiness, Table 5 below identifies how the four principles of credibility, originality, resonance and usefulness discussed above were addressed throughout the research that is presented in this thesis.

Table 5: Trustworthiness of the Research

Credibility	<ul style="list-style-type: none"> • Comprehensive review of the literature in Chapter 2 which currently informs compassion, across nursing and broader disciplines. • Implementation of a stepped approach to the literature review, commensurate with the principles of constructivist grounded theory research. • Clear account of underpinning philosophical and theoretical principles, research methodology and personal worldview provided in Chapter 3. • Full and frank discussion of the implementation of constructivist grounded theory research methods presented in Chapter 4. • Data collection strategy discussed in detail. • Clear account of advancing data analysis, drawing on a data extract exemplar to illustrate this (Appendix 16). • Series of theoretical iterations presented, which preceded and informed construction of the final propositional grounded theory (Appendix 18). • Examples of reflexive activity provided in relation to embodiment, the target sample population, sampling of the initial participant, existing communication skills and location of the individual interviews in Chapter 4. • Limitations of the research are outlined in Chapter 6.
Originality	<ul style="list-style-type: none"> • Constructivist grounded theory methodological approach to investigate compassion in the UK nursing context, specifically within the North East of England. • Research findings drawn exclusively from a sample of individuals who had personal and unique experience of nursing care. • Innovative model of compassion constructed from the propositional grounded theory derived from this research is presented in Chapter 6, providing enhanced insight into compassion in nursing in the UK. • Original and unique focus on compassion through a biopsychosocial lens. • Unique concepts of emerging importance identified through the discussion of the findings in Chapter 6.
Resonance	<ul style="list-style-type: none"> • Diverse sample of participants with experiences of nursing care across a variety of contexts, providing a basis for generality and transference of the findings to other individuals in a range of similar situations. • Blind coding of transcripts to affirm resonance of the emerging interpretation of the findings with research active colleagues. • Comprehensive overview of the research findings providing supporting extracts from the data presented in Chapter 5, enabling readers of the thesis to establish resonance with their own personal perceptions and experiences of compassion.

	<ul style="list-style-type: none"> • Co-construction of the grounded theory through the focus group discussion demonstrates resonance of the research findings to a group of individuals.
Usefulness	<ul style="list-style-type: none"> • The grounded theory provides a platform from which to base future research with other individuals, experiencing nursing care in other care contexts. • Implications for nursing practice identified, and a series of recommendations proposed to address these to enhance future practice presented in Chapter 6. • Findings provide a foundation of knowledge which further informs the existing evidence base that is available to the nursing profession, regarding the complex and diverse nature of compassion. • Grounded theory provides the opportunity for further empirical testing of the model and avenues for further research to expound understanding of compassion in the context of nursing.

4.8 Chapter Conclusion

This chapter has presented a detailed discussion of the research methods that were implemented throughout my research journey. Ethical considerations, sampling, data collection and data analysis have been explored in detail to provide a comprehensive insight into my research journey. Reflexive activity throughout the journey has also been considered, drawing upon some key examples of significance to illustrate this. Transparency has been afforded to the discussion to clarify the audit trail and outline key decisions related to issues such as theoretical sampling and data analysis, with further detailed information available in appendices for scrutiny as required. The chapter represents a robust and rigorous approach to the constructivist grounded theory methods that were implemented, enhancing credibility of the research process and contributing to trustworthiness of the study overall. The following chapter presents the findings from the research.

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Chapter 5: Hearing the Participant Voice-Research Findings

5.1 Chapter Introduction

In the previous chapter, a comprehensive discussion of the methods that were implemented throughout the research process were presented, providing transparency to the audit trail and enhancing trustworthiness of the study. This chapter presents the findings that emerged from the research as a result of extensive data analysis. Throughout the course of data collection, participants shared rich and detailed data, based on experiences they had encountered in a diverse range of hospital, community and private care home environments with nurses and other health care professionals. These experiences were deemed significant and as a result, some were translated by participants to their perceptions of compassion in nursing. Experiences had arisen as a result of personal encounters of nursing care, interpretations of the care experienced by a close relative or vicarious observations of the care delivered to others. Participant experiences extended from the positive to the negative, with a range of mixed experiences falling somewhere in between. This array of experiences contributed to participants developing and constructing their own unique and individual perceptions of compassion in nursing.

It was evident from the data that compassion is extremely complex, influenced by an array of factors that participants perceived to be of significance. Participants recognised the complexity of compassion and acknowledged the diversity of individual interpretation, this is illustrated in the following quote:

“It’s a hard one, compassion you know, because it covers so many things. It’s complicated...compassion means different things to different people” (P6, Individual Interview, p5).

Despite some level of diversity in interpretation there was, however, a clear degree of accordance amongst participants. As a result, five distinct categories emerged from the data (Figure 9).

Figure 9: Data Categories

Category 1:	<i>Self-Propensity for Compassion</i>
Category 2:	<i>Attributes for Compassion</i>
Category 3:	<i>Socialising for Compassion</i>
Category 4:	<i>Conditions for Compassion</i>
Core Category:	<i>Humanising for Compassion</i>

The categories were noted to have a clear interdependent relationship and data analysis suggested that there was potential for factors emerging from one category to impact on another category. To facilitate discussion of the categories and clarify the interdependent nature of this relationship, they are presented in a sequential format. The core category *Humanising for Compassion* is presented last, and links with the other four categories are explicated. Charmaz (2006, 2014) suggests that identification of a core category in constructivist grounded theory is unnecessary, purporting that the aim is to uncover multiple social processes. In this research, although multiple social processes were evident throughout the data and represented within each of the categories, the significance of the core category emerged as being

exceptionally important to participant's fundamental perceptions of compassion in nursing. It was, therefore, vital to acknowledge this.

In order to afford appreciation of participant contributions to the research and to ensure that individual voices are heard, the chapter does not draw upon extant literature. Rather, the discussion is supported by evidence extracted from the data in the form of participant quotations. Presenting the findings in this format provides value to the research participant's narratives and furthermore, supports credibility of the research (Charmaz, 2006, 2014). The source of quotations used throughout this chapter are identified by participant number, type of data collection strategy and page number location in the data transcript.

5.2 Category 1: Self-Propensity for Compassion

The category *Self-Propensity for Compassion* incorporates the properties of *Intrinsic Disposition for Compassion* and *Intrinsic Motivation to Care for Others* (Figure 10).

Figure 10: *Self-Propensity for Compassion: Properties*

Category:	<i>Self-Propensity for Compassion</i>
Properties:	<i>Intrinsic Disposition for Compassion</i> <i>Intrinsic Motivation to Care for Others</i>

Data analysis uncovered that participants perceived *Self-Propensity for Compassion* to be integral to facilitating compassion in the nursing care context. Self-propensity

related to the nurse's predisposition and proclivity for compassion, arising from factors influenced by personality, disposition and character. Possessing *Self-Propensity for Compassion* was regarded as a pre requisite and fundamental foundation, from which to further cultivate compassion in the nursing care context. Participants perceived that the nurse's *Self-Propensity for Compassion* was primarily underpinned by factors of intrinsic personality, which contributed to influencing their decisions to embark upon a career in nursing. This was deemed to arise from an *Intrinsic Disposition for Compassion* and an *Intrinsic Motivation to Care for Others*. Each of these properties are discussed below and supported by participant quotations, with a category summary reiterating key points.

5.2.1 Intrinsic Disposition for Compassion

Participants perceived that, in the first instance, compassion was influenced by factors arising from the nurse's unique characteristic disposition. Possessing a disposition for compassion was considered to be an inherent quality for nurses, manifesting as a result of intrinsic influences arising from their individual personality:

"I think most of them, when they did that [acted with compassion], it was a natural thing... they just did it because that was their personality" (P2, Focus group, transcript 1, p9).

The importance of intrinsic personality was further evident through perceptions that an individual either possessed, or failed to possess, a personality that was underpinned by *Self-Propensity for Compassion*. This suggested that some nurses demonstrated an ability to be compassionate, whilst others did not:

"It[compassion] has to be in everybody doesn't it, you either have it or you don't" (P8, Individual Interview, p10).

Compassion was regarded as an integral aspect of personality that was present within the individual. It was perceived as a characteristic that was not specifically taught, rather, participants considered it to be an integral component of the nurse's personality, arising from their intrinsic predisposition and proclivity for compassion:

"I think they've just got a natural application for it [compassion]. They don't have to be taught it, they instinctively do it" (P3, Focus Group, Transcript 1, p8).

Participants were able to identify particular nurses who appeared to have an enhanced *Self-Propensity for Compassion*. This highlighted that through their experiences of nursing care, they perceived differing levels of self-propensity amongst the nurses who had cared for them. A minority of nurses seemed to be equipped with an intrinsic ability to go above and beyond the realms of what could be regarded as typical nursing care practice, paying attention to what participants often considered to be small acts of kindness. This suggested that participants perceived many nurses had failed to consider such acts, throughout their experiences of nursing care. The ability of this minority of nurses to engage in small acts of kindness, elevated the level of compassion that they demonstrated and, as result, participant perceptions of compassion were significantly enhanced:

"Some just have it in them to go that extra mile, I'm not sure why, they must just be made like that... those little extra things, they make such an enormous difference" (P1, Individual Interview, p27).

As a result of perceived levels of enhanced *Self-Propensity for Compassion*, the data suggested that such nurses were significantly distinct from others. Although participants were unable to fully discern the reasons for this, they clearly identified

that there was something different about these particular nurses as an individual, which clearly motivated their personal levels of competence for compassion:

“I can’t tell you what it was, I can’t put my finger on it really, but there was just something about that nurse...he was different from the others, just something about him as a person, something that made him put himself out for me...especially when I felt at my lowest point” (P10, Individual Interview, p5).

Analysis of the data also identified that participants perceived that possessing an *Intrinsic Disposition for Compassion* had the potential to influence the nurse’s *Intrinsic Motivation to Care for Others*.

5.2.2 *Intrinsic Motivation to Care for Others*

Possessing an intrinsic *Self-Propensity for Compassion* was regarded as a key motivating factor to influence people to enter the nursing profession. The notion that this arose from inherent factors was apparent, with suggestions that nurses possessed unique caring attributes which specifically located them in a position to assume a role in nursing:

“I think they go in because they are a caring person to begin with...it’s sort of inbred in you really, it’s such a strange thing, it’s as though you’ve got a stamp on your head” (P6, Individual Interview, p17).

It was evident that having an *Intrinsic Motivation to Care for Others* was assumed to be inextricably linked to an *Intrinsic Disposition for Compassion*. The perceived links between personality and motivation to embark on a nursing career were apparent in the data, underpinned by the belief that individuals were led to nursing as a direct result of the intrinsic caring and compassionate personality that they possessed:

“it’s all to do with the person and they’re led to it because they are a caring and compassionate person...that’s got to come from within...it’s a personality thing” (P1, Individual Interview, p15).

In addition to perceptions that nurses possessed intrinsic factors which were instrumental in leading them to nursing careers, it was also apparent that participants perceived compassionate nurses to possess an intangible penchant. This was regarded as something that could not be fully understood or explained, perhaps reflecting perceptions of what participants considered to be the unique nature of nurses and nursing. This proclivity for nursing seemed to be regarded as a key motivating factor influencing decisions to embark on a nursing career, driven specifically by intrinsic and innate personality factors:

“I think there’s something in people, isn’t there, that makes you want to be a nurse and care for people...if we could bottle it, understand what it is. People [nurses] just have that something...it’s something you can’t really get to grips with” (P5, Individual Interview, p13).

Participants who had only encountered positive personal experiences of nursing care perceived that individuals without an *Intrinsic Disposition for Compassion*, would not be positioned in the nursing profession. This suggested that possessing a *Self-Propensity for Compassion*, driven by an *Intrinsic Motivation to Care for Others*, was an integral and expected requirement of all nurses. Following a single prolonged and extremely positive nursing care experience in an Intensive Critical Care Unit (ICCU), one participant proclaimed that all nurses were compassionate, suggesting that those who were not would not choose to pursue a career in nursing:

“It’s just with the profession, they’ve got this caring sort of attitude...I suppose if they didn’t have that, if they weren’t that character, they wouldn’t be in nursing” (P2, Individual Interview, p9).

However, participants with a more extensive range of nursing care experiences refuted the assumption that all nurses possessed *Self-Propensity for Compassion*. As a result of negative experiences, participants were able to establish differentiations amongst individuals, highlighting instances where they perceived nurses to lack an *Intrinsic Disposition for Compassion*. Following a series of negative encounters in a local General Practitioner's surgery, a participant described the enduring poor attitude of the Practice Nurse, identifying that she was devoid of the intrinsic disposition that was required of individuals to perform the nursing role:

“she lacks compassion...I don't think she's got a compassionate bone in her body to the job she does” (P4, Individual Interview, p9).

Following a negative experience observed whilst accompanying a friend to an outpatient appointment, another participant noted a nurse failing to exhibit any interest in establishing a relationship, or interacting with the person she was dealing with. This experience led the participant to assume that the nurse lacked *Self-Propensity for Compassion*, and as a result, questioned her position, and competence, to be in the nursing profession:

“sometimes I think some people shouldn't be nurses...they're not able. I think there's something about their personality, they can't relate to people...they're not able to be compassionate” (P5, Individual Interview, p13).

The notion that individuals who lacked *Self-Propensity for Compassion* were inappropriate for nursing careers, was evident across the data. *Self-Propensity for Compassion*, particularly in relation to *Intrinsic Motivation to Care for Others*, was regarded as essential for nurses. In instances where this was not apparent, participants assumed that these individuals had made the wrong career choice.

Following vicarious observation of negative experiences of her husband, a participant suggested that nurses who lacked the intrinsic ability for compassion should not be in the profession, due to an inability to respect the people they were caring for as fellow human beings:

“I mean there’s a lot of people on this earth who don’t have compassion. But you have to have love for your fellow man, if you don’t you’re in the wrong job...I would say that nursing actually, it’s not a profession, it’s a vocation really. You’ve got to go in because you want to do it...you’ve got to have that compassion inside you, because if you haven’t...don’t be a nurse” (P8, Individual Interview, p9).

The notion that nurses may be in the profession simply for motivations arising from financial factors, was identified as an inappropriate motivating influence to embark on a nursing career. A participant recalled experiences with several nurses, with whom she perceived this to be the case. It was evident that financial reward for nursing was considered a somewhat distasteful notion, in contrast to a desire to care for others with compassion, which was regarded as the most acceptable reason for embarking on a career in nursing:

“I have often in the past come across people where you have just thought they are in the wrong job, they are just doing it for the money...you have those that stand out a mile like that...they shouldn’t be there” (P11, Focus Group, Transcript 1, p7).

The data identified that recruitment strategies needed to specifically seek individuals who were equipped with *Self-Propensity for Compassion*, thus ensuring that nurses were selected appropriately for their personal proclivity and disposition in the first instance. During the focus group discussion, participants reiterated the importance of *Self-Propensity for Compassion*, reinforcing the belief that recruitment strategies to elicit this were essential. Although knowledge and education were highlighted as important, the requirement to possess a fundamental personality, attitude and

disposition for compassion was regarded to be of the utmost importance. The notion that *Self-Propensity for Compassion* was dependent on intrinsic disposition and motivation to care for others was also further substantiated, through claims that compassion originated from biological influences associated with hereditary forces:

“P2: Well I think obviously, you can teach them the job but the actual compassion bit, I mean, they have either got it or they haven’t really I think, you know.

P3: That’s in-bred.

P11: You put all your faith into the profession and you hope that they are going to be able to make you better, you know, and not in [names husband]’s case, but if you go into hospital then you expect the best. You have the people that are looking after you, the doctors and the nurses, who have had excellent training, hopefully there is more training going in now. It all comes down to attitudes, if you are a nurse and you haven’t got compassion...I think really you have to go back to square one when you appoint your staff, your new staff, be it new doctors or new nurses and students coming in, you are looking for that extra quality.

P3: Yeah.

P2: Because somebody could have all the best brains in the world, but they are not going to be a good doctor and they are not going to be a good nurse...if they haven’t got compassion

P11: We’ve come back to it, you have either got compassion in you or you haven’t” (Focus Group, Transcript 2, p2).

5.2.3 Category Summary

In summary, the category of *Self-Propensity for Compassion* reflected participant perceptions that primarily, compassion arose from intrinsic influences which could shape an individual’s disposition for compassion and ensue in a motivation to embark on a nursing career to care for others. Participants perceived *Self-Propensity for Compassion* to be an essential and fundamental requirement for nurses, and an integral antecedent which could influence an individual’s decision to pursue a nursing career. The existence of differing levels of individual self-propensity was highlighted in the data, with participants suggesting that some nurses demonstrated an enhanced *Self-Propensity for Compassion* and were often willing to go above and beyond the call of duty to meet the needs of others. When individuals were perceived to be lacking in self-propensity, participants made assumptions that they had chosen

to pursue an inappropriate career pathway. The overarching perceptions of participants identified that they regarded *Self-Propensity for Compassion* to be a pre requisite foundation, from which to facilitate compassion in nursing. When participants encountered an experience with a nurse who demonstrated an intrinsic *Self-Propensity for Compassion*, they were more likely to perceive the experience as compassionate. Conversely, in instances where nurses exhibited a lack of intrinsic *Self-Propensity for Compassion*, participants were more likely to perceive the experience as uncompassionate.

5.3 Category 2: Attributes for Compassion

The category *Attributes for Compassion* incorporates the properties of *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion* (Figure 11).

Figure 11: Attributes for Compassion: Properties

Category:	<i>Attributes for Compassion</i>
Properties:	<i>Personal Attributes for Compassion</i> <i>Professional Attributes and Interactions for Compassion</i>

Analysis of the data uncovered a wide array of attributes which participants perceived to be representative of compassion in nursing, elicited as a result of their individual and unique nursing care experiences. The data suggested that many of these attributes were associated with personality and a wide range of attributes were

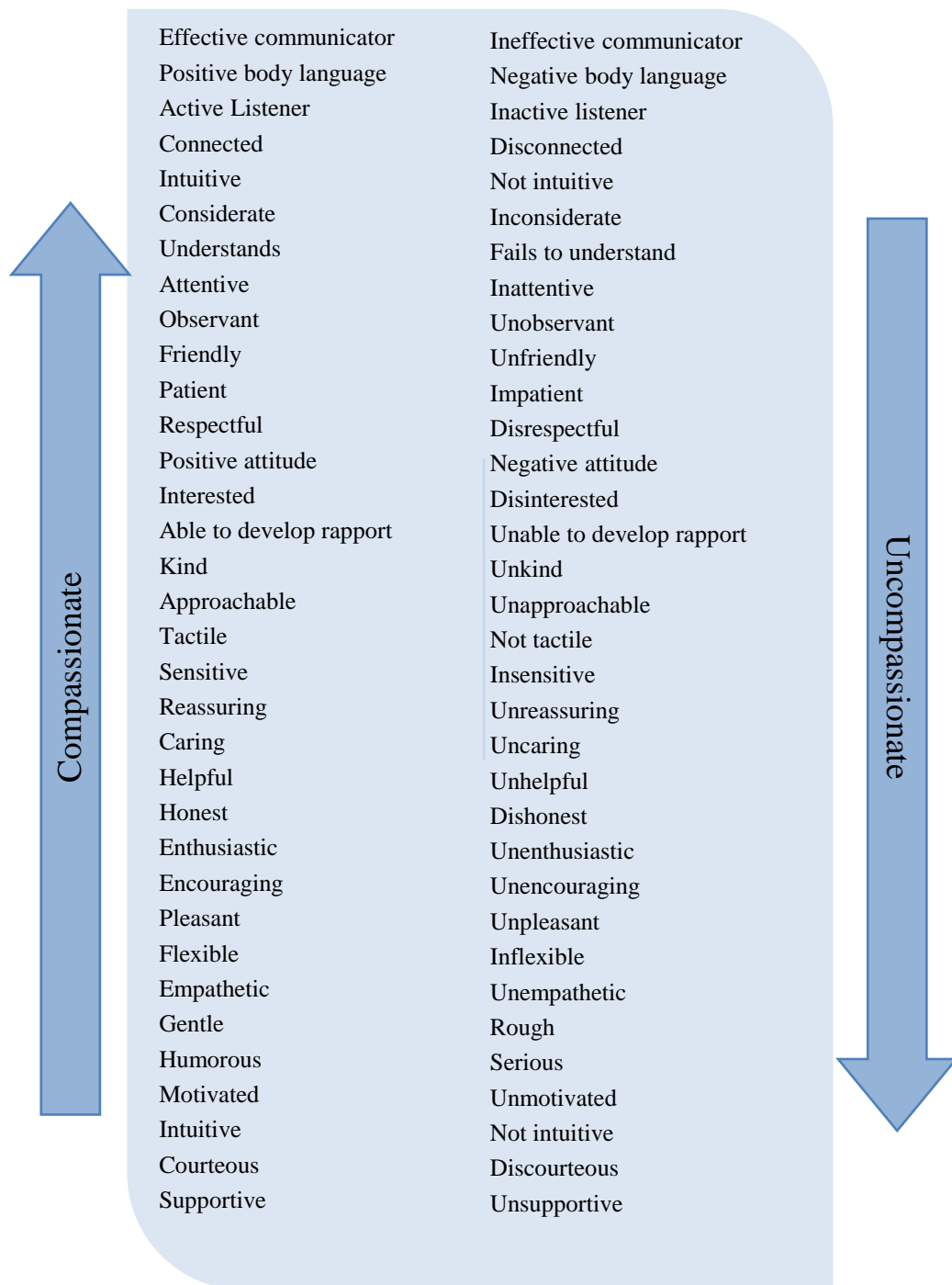
identified to reflect this. There was a strong sense that participants perceived many of the *Attributes for Compassion* to arise from intrinsic personality, particularly in relation to those identified to represent personal attributes.

In terms of professional attributes and interactions, there was a strong sense that although there may be intrinsic influencing factors, there was also potential for extrinsic factors to have an impact, a notion that is explicated in the discussion of category 3. There was a convincing level of accord across the data that an extensive range of personal and professional attributes were associated with participant perceptions, specifically relating to what compassion involved. The category properties relating to *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion* are discussed below and supported by participant quotations, with a category summary reiterating key points.

5.3.1 Personal Attributes for Compassion

A wide range of personal attributes were highlighted from the data as being representative of compassion, with some degree of variation noted in relation to the specific attributes identified. This variation perhaps reflected differing social realities and constructed interpretations of what compassion was perceived to involve, inevitably emerging from unique and individual care experiences. Despite these variations, there were clear similarities across participants in terms of perceiving the notion of personal attributes to be representative of, and integral to, compassion in nursing. The findings revealed an array of attributes which participants perceived to be symbolic of what compassion in nursing involved. An extensive range of personal attributes were elicited from the data through initial coding across all data collection events, and are outlined below in Figure 12.

Figure 12: Dimensions of Personal Attributes for Compassion



In addition to personal experiences of nursing care, some participants drew upon their own personal life experiences, informal caring roles or involvement with voluntary organisations. In doing this, they provided examples of where they

perceived they had observed compassion in nursing, or demonstrated compassion themselves. A participant articulated links between her personal demonstration of compassion as a former medical receptionist, translating this to her perceptions of compassion in nursing to identify a wide array of personal attributes which she deemed to be representative of compassion. The key attributes identified related to kindness, non-verbal communication, offering reassurance, taking an interest, being gentle and assuming a positive approach:

“There are so many interpretations, to me it means, well it’s kindness, it’s often to do with body language...put them [individuals] at their ease, to be open to them ... it’s partly to do with your personality...there’s all sorts of things I’m not good at, but I’m quite good with people, I like people, I’m interested in people...similarly in hospital, and the same prerequisites there you know... some nurses are so excellent at it, you know, they’re not sort of all over you but they’re kind, they’re gentle, they’re sympathetic and they don’t hustle you and bustle you around.....it’s the whole approach, and some people have this approach and others don’t” (P1, Individual Interview, p 5/6).

Across the data, participants illustrated many positive examples of nurses exhibiting personal attributes that they perceived to be representative of compassion. One participant shared her experience of having a leg wound dressed, highlighting the way in which the nurse took an interest in her, communicated effectively and developed a connection to identify her low mood. As a result, the participant identified how these attributes were translated into interactions that she regarded to be reflective of compassion:

“They weren’t just interested in the wound on my leg, they noticed I had a low mood...just being able to talk to her [the nurse] for, just for five, ten minutes...it made such a difference...she took time to listen...there’s different ways of showing compassion. It’s not necessarily having to sit with people and sob, it’s just tuning into people” (P3, Individual Interview, p4).

Another participant shared her experience of undergoing diagnostic interventions, throughout which she was extremely anxious. She identified that attributes related to being gentle and showing kindness were translated into interactions to offer reassurance in response to her anxiety, representing what she perceived compassion to involve:

“Everybody was really gentle with me and caring and understanding...really kind and asking you how you were feeling and was there anything worrying you...taking an interest...reassuring you” (P5, Individual Interview, p9).

In response to a probe to elaborate on what compassion meant to her, one participant drew upon the nursing care experiences of her husband to illustrate that compassion involved attributes associated with using touch, understanding the person, being sympathetic, involving the family, making connections and tuning into the individual:

“I think it’s the ability to perhaps put your arms around somebody, to really understand what the person is going through, to feel the utmost sympathy without being maudlin. To understand that person is really frightened ...take the trouble to talk to the family, find out more about the person...to be part of their world really. You can’t expect the person with Alzheimer’s to be part of your world, you have got to go into theirs” (P11, Individual Interview, p12).

Participants also illustrated negative examples of nurses failing to exhibit the personal attributes that were perceived to be representative of compassion. Negative examples often involved nurses exhibiting a complete lack of interest in the person, beyond the remit of competently delivering an adequate level of clinical nursing care. One participant recounted her experience in an outpatient clinic where she felt objectified as she was expedited through the system. Although nurses demonstrated clinical competence and skill, the lack of communication, reassurance and general interest in her, led her to perceive she was insignificant as a person:

“I was treated like a piece of meat, a number, as if I was on a production line...the production line was efficient enough, the competence and skill was there, but there was little in the way of what I would consider to be compassion...there was no eye contact, nothing really...no reassurance...no interest in me whatsoever” (P7, Individual Interview, p2).

Another participant highlighted an observed negative experience involving her husband, who was exhibiting challenging behaviour due to a urinary tract infection which was impacting on his dementia. The participant identified how the nurse failed to exhibit personal attributes for compassion, instead exhibiting a lack of interest, a negative attitude, a failure to connect and extremely poor communication skills. The nurse was identified to be simply focusing on the task of discharging her husband back to his care home:

“My husband was in A/E...he was volatile, extremely agitated...in about half an hour they came back with a packet of pills, antibiotics, and said “there you can go home now” ...their attitude, they just wanted him out of there...no compassion, no compassion at all...I asked if they could get an ambulance and they said there weren’t any at that time. Well I said, how am I going to get him back then...she [the nurse] said “well that’s your problem” and shook her shoulders and walked out” (P8, Individual Interview, p5).

When examples of uncompassionate care experiences were provided during data collection, participants were able to identify attributes and behaviours which they perceived should have been implemented by the nurses involved. Attributes relating to issues such as seeing things from the individual’s perspective, being empathetic, having patience and demonstrating an appropriate attitude to others, were strongly elicited in the focus group discussion to address the negative care experiences that some participants had encountered. Participants highlighted that although clinical knowledge and skills were important, it was essential that compassion, exhibited through appropriate personal attributes, accompanied this:

P11: The thing is, any nurse or any doctor or any member of staff who treats somebody disrespectfully and without compassion, if it was their relative in the bed, they wouldn't be doing it.

P3: Yes, they've got to put themselves in your shoes. It's the empathy, coming alongside somebody and thinking "what if that was me?" ...if they don't have that, you're missing out on the next stage, which is dignity...you can have all the clinical skills in the world but if you haven't got the compassion, then you're not going to be such a good nurse...the right attitude, definitely."

P11: I think to be patient too...you'd be surprised how many of them aren't...they wanted to get things done as quickly as possible" (Focus Group, Transcript 1, p6).

Examples of participant experiences across the sample reflected a strong focus on positivity as a pre requisite to foster compassion. Participants perceived that a positive approach was fundamental to compassion. In the absence of positivity, the associated personal attributes deemed representative of compassion were considered to be lacking:

"If you're not positive, then what is there, nothing...its crucial to have a positive outlook otherwise everything else juts goes pear shaped. A positive mental attitude is important, if you don't have that... you've got nothing" (P7, Individual Interview, p3).

Positivity in terms of attitude, enthusiasm, interest and motivation to engage with people in a manner that fostered compassion, were clearly articulated as key personal attributes across participant data. An example of a participant's experience in ICCU demonstrated the positive approach adopted by the nurses caring for him to overcome the challenges of the aggressive behaviour he was exhibiting as a result of his presenting condition. As a result of this level of positivity, compassion was perceived in an extremely positive light:

"The nurses were there all the time and there was nothing any bother to them... I was a bit grumpy and was like giving them stick and that, like. Which isn't me, but, like it was just the way I was. But they were just fabulous and, you know, it was just a case of like, you know, if I wanted anything, they were like there straight away...they were just so positive" (P2, Individual Interview, p9/10).

The data suggested that having a positive attitude was key to nurses subsequently being able to assume an enthusiastic and motivated approach to nursing care, which was often reflected in their capability to take an interest in people. Positive approaches and attitudes were perceived to be instrumental in affecting the nurse's ability to demonstrate compassion in all aspects of their nursing care practice. The data suggested that positivity was central to, and interrelated with, the individual's capacity to display personal attributes, which participants perceived to be representative of compassion.

Effective communication was a key dimension of personal attributes, identified by participants as an integral aspect of facilitating compassion. Verbal communication was regarded as vital to foster positive perceptions of compassion and essential in the development of relationships. A participant discussed a positive experience of communication which involved receiving news of her father's death. The implementation of effective communication skills to deliver this bad news were founded on the nurse being genuine, honest and making a connection with the participant in difficult circumstances. These attributes were considered to be the foundation for compassion:

"The way she told me that my dad had died...When you talk about compassion...it was the way the nurse said it to me, the way she said "sorry to tell you he's had a heart attack". I can't explain it, it was just the way she explained it, it was quite genuine and that really helped me quite a bit" (P9, Individual Interview, p2)

The use of non-verbal communication and positive body language were also highlighted to be important by many participants. A participant recounted an experience of what she described as good quality clinical care, but which

simultaneously lacked compassion. Contrasting this with positive experiences, the participant identified effective non-verbal communication to be the key differential variable. In instances where nurses demonstrated effective non-verbal communication, using eye contact and facial expression to cultivate an empathetic connection with the person, a more positive experience of compassion was perceived:

“There was no feedback, facial feedback. There was no sort of eye contact, I mean, everything was done properly, you know, it was very clinical. Very clinical. There was no empathy. That’s what I felt. That the ones that were good were very opposite. You know, really opposite and you know, you felt as if you were being cared for” (P5, Individual Interview, p6).

In further support of the value of non-verbal communication skills, another participant drew upon a positive experience of care to illustrate this. During a minor surgical procedure, the participant described how a nurse held her hand throughout. This experience of touch offered reassurance and reduced anxiety throughout a distressing event. This was coupled with effective verbal communication, which supported her to feel cared about through the connections that were developed as a result:

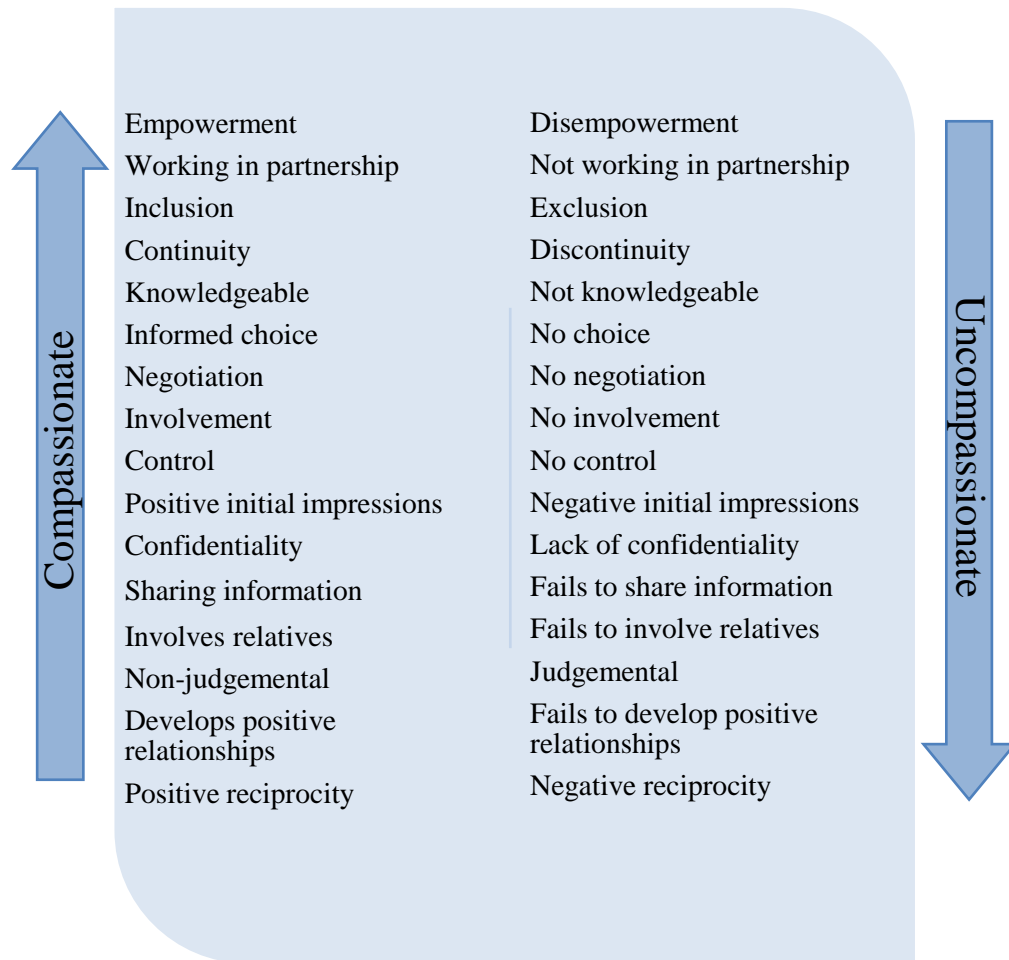
“The nurse held my hand ‘that’s all the injections done...now, would you like me to continue holding your hand?’... that girl sat and held my hand the whole way through that surgery...everybody was saying ‘are you alright’ ...they were just so lovely” (P4, Individual Interview, p7).

In addition to *Personal Attributes for Compassion*, a range of *Professional Attributes and Interactions for Compassion* were also evident across the data to reflect what participants perceived compassion to involve.

5.3.2 *Professional Attributes and Interactions for Compassion*

Participants identified a range of professional attributes and interactions which they considered to be representative of, and synonymous with, compassion in nursing. Participants drew upon experiences that they had encountered in a variety of care contexts to illustrate this, often utilising examples arising from interactions with other health care professionals. Despite some of these examples involving other health care professionals, participants proceeded to translate these experiences to their perceptions of compassion in nursing. Participant experiences were varied, and as a result, a range of professional attributes and interactions were identified from the data. Despite some diversity, there was a high degree of accord among participants, highlighting a wide range of professional attributes and interactions to be symbolic of compassion in nursing. The range of *Professional Attributes and Interactions for Compassion* elicited from participant data through initial coding across all data collection events, is outlined below in Figure 13.

Figure 13: Dimensions of Professional Attributes and Interactions for Compassion



It was apparent from the data that positive initial impressions were often at the heart of what ensued to influence participant perceptions. Participants suggested that a positive initial impression was instrumental in laying the foundations for the succeeding compassionate interactions that ensued. A participant illustrated how an experience of day surgery influenced the development of positive perceptions of compassion from the outset of her care trajectory. The experience highlighted the importance of initial contact with nurses and other health care professionals, and indicated that this was essential to develop connections, initiate relationships and engage in effective communication:

“Compassion to me...it’s the approach by the reception, straight away you know, it’s from going in. It’s how they receive you at the reception desk, then you are taken to a nurse, how that nurse receives you and what she’s like with you and how she treats you...in my experience, they’ve all made me feel like the most important person and very special...they have talked to me...told me what’s happening...they just made that whole experience” (P4, Individual Interview, p5).

In instances where participants perceived negative initial impressions, the potential to impact on the subsequent professional relationship was evident. During an experience in an outpatient clinic, a participant described how initial impressions negatively influenced the development of the subsequent professional relationship with the nurse. A lack of non-verbal cues and ineffective communication resulted in an ensuing failure to establish a positive relationship:

“My first impressions of her [the nurse] were dreadful...she didn’t give me any eye contact, she didn’t really see me, she just asked me a list of questions and that was that. I thought to myself, well two can play at that game...so, that was the end of that, I just shut myself down” (P7, Individual Interview, p11).

Another participant highlighted an encounter with a Doctor, who failed to introduce himself when assessing her medical charts. She voiced her dissatisfaction to the ward sister and although this prevented any future similar incidents, the ensuing professional relationship was negatively impacted. The incident highlighted the importance of professional introductions, indicating the essential nature of this in terms of developing professional relationships:

“This particular doctor came in, looked at me as if I was something out of the Hancock museum, looked at my chart and walked out. He didn’t even introduce himself, he didn’t say where he was from, he could have been the plumber in a white coat, with an axe under his coat... common courtesy is required...he could have been anybody” (P3, Individual Interview, p9).

Further to initial impressions, the importance of assuming a non-judgemental approach was evident in the data. In instances where participants encountered what they perceived to be a judgemental approach from the nurse, perceptions of compassion were negatively influenced. One participant identified several experiences of nurses assuming a judgemental approach towards her partner who was alcohol dependant. As a result, she was clear in articulating that it was imperative for nurses to avoid making assumptions about people and adopt a non-judgemental approach to demonstrate appropriate interactions for compassion:

“Compassion is only there if you know what’s in front of you, if you know this and leave your judgemental heart at home before you leave for work” (P9, Individual Interview, p13).

The importance of providing information to facilitate choice, empowerment and a degree of control over the individual care experience was clearly evident from the data. Participants desired the opportunity to be involved in decision making processes which enabled them to take an active role in their care experience, and they welcomed appropriate professional attributes and associated interactions which supported this. When participants experienced an inclusive level of professional interaction, perceptions of compassion were more positive. A participant illustrated this through an example of her involvement in decision making about her treatment and care. Although the actual encounter was with a doctor, she was clear in articulating that the same principles of involvement and inclusion also applied to nurses:

“Being a kidney patient, my veins are shot, they’re rubbish...I had a particular doctor who knew I hated needles and when I needed antibiotics once, he said ‘well the better ones, the quicker ones would be the intravenous ones’. He saw my face drop, so he said ‘I’ll tell you what, I’ll strike a deal with you, we’ll try the oral ones first and we’ll see how you’re going...but he didn’t just sort of rush straight

ahead...he involved me...it should be the same with nurses” (P3, Individual Interview, p7).

In addition to inclusion at an individual level, participants identified the importance of providing information to facilitate carer and relative involvement in decision making. When relatives were not involved or enabled to contribute to decision making processes, participants were more likely to perceive the experience to be lacking in compassion. A relationship focused approach was central to this, within which effective communication and shared decision making was regarded to be of the utmost importance. A participant highlighted how a lack of a relationship focused approach ensued in her perception of an uncompassionate experience, as nurses failed to involve her in the discharge planning process for her husband:

“The lack of care, the lack of compassion, a really bad case...he [her husband] was supposed to be discharged...I wasn’t told about it, no one talked about it, no one asked if everything was in place...all this should have been in place and discussed, discussed with me and nothing was discussed” (P8, Individual Interview, p6).

Participants required professional attributes and ensuing professional interactions which enabled both them, and their relatives, to regard themselves as partners in a care experience which promoted empowerment, choice and a sense of control. Positive professional attributes and interactions were perceived to be compassionate, whilst negative professional attributes and interactions were perceived to be uncompassionate. It was apparent from the data that facilitating equality in the relationship was essential for an ensuing partnership approach to care, which fostered negotiation and involvement in decision making processes. Participants sought an active role in the professional relationship, which was founded on mutually reciprocal exchanges. They desired to be positioned at an equivalent level

with the nurses and health care professionals who were caring for them. Participants perceived compassion more positively in encounters which afforded the opportunity to be involved in decisions made with them, rather than about them. The notion of equality was central to this and illustrated in the following data extracts:

“I was given a choice...that made me feel included, like I mattered to them...I didn’t feel like a spare part, more like I was on the same level as them” (P7, Individual Interview, p3).

“You expect them to be compassionate...to be treated as an equal” (P3, Individual Interview, p8).

The data suggested that the issue of power was fundamental to professional attributes and interactions and thus, the ensuing experience of compassion. Some of the examples provided by participants related to interactions with medical staff. These experiences had significantly influenced their constructions and perceptions of compassion and, as a result, they discussed the issue of power as equally applicable to nursing. In circumstances where participants sensed a negative power balance, they perceived a lack of involvement, which had the potential to negatively impact the professional relationship. There appeared to be an association between the issue of power and perceptions of equality, which had the potential to impact on professional interactions for compassion. A participant illustrated this through an experience with a doctor who asserted his position of authority, power and knowledge to dismiss her concerns over a stroke diagnosis:

“He was like a little Hitler, that’s the only way I can describe it...when he walked in, he had the swagger...he was checking me over and honestly, I felt as though he thought I was putting it on...when he came in he had a smirk on his face...and he said well, I knew that I was right, it wasn’t a stroke” (P6, Individual Interview, p10).

Another participant who had experienced a life time of care interventions due to a birth disability, highlighted ongoing power issues involving both nurses and doctors. Her experiences suggested that professionals often placed themselves in an elevated position from the person they were caring for. This impacted on the subsequent professional interactions that followed, leading to exclusion of the participant in decision making about her care:

“The attitude used to be, oh well, you are just the patient, you know nothing...I am the expert, I am qualified, you listen to me...so arrogant, just dismissed me out of hand...it’s the same for nurses you know” (P3, Focus Group, Transcript 1, p13).

The data also highlighted that participants desired to be addressed appropriately in the care context. Some participants felt very strongly about nurses using their given name without consent, or addressing them using terms of endearment. When participants were not addressed in their preferred style, this seemed to contribute to an underlying sense of a power imbalance in the relationship and as a consequence, a perceived lack of compassion. One participant held very strong beliefs that she should be addressed accordingly. Her experience suggested that when nurses used terms of endearment to address the individual they were caring for, this resulted in perceptions of poor communication strategies, ineffective professional relationships, a lack of respect and a degree of ostracism:

“I think it’s nice to be talked to as if you know what you’re talking about. Not talked down to. This is a definite, you know, nobody’s ever called me granny thank God, but someone did to this old lady who was very refined. A sensible old lady who sort of said “my dear, unfortunately I am no one’s granny, but I am most certainly not yours”...just to assume you can call anybody by their Christian name...to older people it’s nice to have the choice. You’ve got so little dignity left, you know you cling on to what you’ve got” (P1, Individual Interview, p11).

The data also identified that when reciprocal equality was offered in relation to how participants were addressed, it was more likely that the participant would consider this to be an acceptable professional interaction. For example, a participant highlighted that when she was invited to address the nurse by their given name, she accepted that her given name could subsequently be used. This suggested that when an equal power balance was facilitated through a mutually respectful and reciprocal relationship, participants were more likely to perceive the interaction as positive:

“I found it difficult to get used to some snippy young person coming along and saying “D” [uses Christian name]...but as long as I equated it, as long as they gave me their Christian name, I accepted that they could use mine” (P1, Individual Interview, p6).

5.3.3 Category Summary

The findings so far suggest that participants constructed their perceptions of compassion in nursing via their experiences of a variety of social processes, encountered in a variety of care and everyday social contexts. In the first instance, they perceived that nurses required intrinsic *Self-Propensity for Compassion*, and made assumptions that this could influence decisions to embark on a nursing career. Individuals who lacked self-propensity were considered inappropriate for nursing and in circumstances where such individuals did opt to become nurses, participants suggested that they had elected to pursue the incorrect career pathway. Compassion involved a wide array of personal and professional attributes, which influenced the nurse’s subsequent interactions with the individuals they were caring for. Personal attributes included kindness, patience, empathy and assuming a positive approach. Professional attributes and interactions included providing information to facilitate choice and control, fostering equality, working in partnership and promoting a sense of involvement by engaging in negotiation. There was a clear sense from the data

that these *Attributes for Compassion* were strongly influenced by intrinsic personality factors. However, the data also suggested that extrinsic factors had a significant role to play. Overall, the data indicated that when nurses demonstrated appropriate personal and professional attributes and interactions, participants were more likely to perceive the experience to be compassionate. When nurses failed to demonstrate appropriate personal and professional attributes and interactions, participants were more likely to perceive the experience to be uncompassionate.

5.4 Category 3: Socialising for Compassion

The category *Socialising for Compassion* incorporates the properties of *Educating for Compassion*, *Role Modelling for Compassion* and *Leading for Compassion* (Figure 14).

Figure 14: Socialising for Compassion: Properties

Category:	<i>Socialising for Compassion</i>
Properties:	<i>Educating for Compassion</i> <i>Role Modelling for Compassion</i> <i>Leading for Compassion</i>

Whilst participants acknowledged that *Self-Propensity for Compassion* and *Attributes for Compassion* could be influenced by intrinsic factors, they also acknowledged the influence of extrinsic factors. The data indicated that these extrinsic factors related to *Socialising for Compassion*, incorporating strategies relating to *Education for Compassion*, *Role Modelling for Compassion* and *Leading*

for Compassion, which participants deemed essential to nurture and sustain compassion in nursing. These three category properties are discussed in turn below and supported with participant quotations, with a category summary reiterating key points.

5.4.1 Educating for Compassion

Participants identified the value of nurse education, as a strategy to further enhance and develop intrinsic *Self-Propensity for Compassion* and *Attributes for Compassion*. In the focus group discussion, the significance of nurse education was highlighted to be of fundamental importance, particularly in terms of augmenting the existing intrinsic personal and professional attributes of the nurse. The notion that nurse educators themselves required attributes for compassion was suggested as an important aspect of educating for compassion through example. Education was considered to be a means to nurture an existing disposition for compassion, by teaching nurses to appreciate the need to develop appropriate knowledge to underpin their practice and apply this to the care of others:

P3: Well, I think the right training is vital...and if they are not a very compassionate person that's delivering it, you are not going to hand that on really.

I: Right, so you are talking about the educator, the person teaching them?

P2: Yeah, unless it's in-bred and it's there already. But you still need it nurturing, you still need it bringing out.

I: Aha, aha.

P11: Well I am lucky enough to have been invited to talk to the nurses in their training and I think from what I can see is that if they understand the illness, so, you know, it could be any illness, for me it's just dementia, they feel far more confident when they go on the ward, they have a different approach to how they are going to be dealing with people, so education is paramount really

(Focus Group, Transcript 2, p1).

Participants purported that nurse education was a vehicle to move intrinsic compassion forward, supporting nurses to maintain it as an integral component of nursing practice. Developing appropriate knowledge of presenting conditions was

identified to be important, particularly in terms of understanding people and appreciating situations from their point of view. A participant illustrated this articulately following observation of her husband's experience of care, highlighting the significance of having knowledge and understanding of dementia to support compassionate nursing care:

“If you’ve got somebody in the later stages of Alzheimer’s and they don’t have the words to say they’re in pain, the nurses need to recognise what real pain is. Because if they don’t, then the compassion wouldn’t be coming... you’ve got to understand the illness, because all the training in the world is not going to mean that you are going to give the best compassionate care if you don’t really understand why somebody’s behaving as they are...I think the answer definitely lies in education” (P11, Individual Interview, p6).

Participants also identified that education which placed value on learning from the encounters of people who had experienced nursing care, was a significant strategy to facilitate compassion in nursing. Nurses needed to be cognisant of the individual's point of view and use this as a learning platform, from which to develop nursing care approaches which facilitated positive experiences of compassion. This involved learning from the real life experiences of others, in order to enable nurses to see things from this unique perspective:

“It’s all to do with the training they’re being given...they should want to learn from us...that’s how the nurses should be taught...that will give them their thinking and their actions” (P1, Individual Interview, p14).

The role of formal educational strategies during initial nurse education and beyond, was outlined by many participants as the cornerstone of facilitating compassion in the nursing context. Participants indicated that formal educational strategies were a means to further develop intrinsic self-propensity and appropriate attributes to perpetuate compassion in nursing. This could support nurses to internalise

compassion as an integral part of their personal philosophy of nursing, facilitating implementation of compassionate care in everyday practice. The data suggested that education should be ongoing in the post registration period in order to support nurses to sustain compassion, thereby minimising the potential barriers that nurses may face in the care context:

“You need to have more training of qualified staff on the ward so that they have the same approach, it’s no use having all the training coming in if they [students] hit a buffer when they go onto the wards” (P11, Focus Group, Transcript 2, p2).

Some participants built upon the notion of education further, highlighting the value of wider educational strategies to nurture compassion. Education through experiential learning in general social life was considered to be a major influence in developing the ethos of compassion in both the individual, and wider society as a whole. One participant drew upon her own personal life experiences, which she identified as being instrumental in supporting her to develop personal values for compassion. This suggested that being exposed to compassion in the home environment from an early age, was a significant factor in supporting compassion in the adult years:

“I had a brother who had muscular dystrophy....in those days they only lived until about 17, so my mother... she became alcohol dependent. I think I learned a lot about compassion from then, because I’ve been a carer most of my life...I’m just someone who has a bit of compassion for people because of my own experience in life...it starts at primary school, the schools do a good job but sometimes it gets lost...it needs to be nurtured in the home too” (P9, Individual Interview, p11).

The significance of education for compassion in the formal school environment was additionally identified as an appropriate means to build upon compassion learned in the home environment. Some participants highlighted that compassion should be an integral part of everyday life, taught in both homes and schools to facilitate societal

acceptance of compassion as a cultural norm. Learning about compassion and engaging in acts of compassion at home and school, was identified as integral to facilitating compassion in the adult years. Socialising for compassion through educational strategies within the wider context of society was perceived to be a mechanism to support individuals to internalise compassion, thus contributing to the development of a more compassionate individual:

“I was taught about compassion at school, it was something we learned about when we were young...to go out and help people. I was even encouraged to do the same at brownies and guides to get our badges and awards. I can remember helping old people who lived close by, to do their gardens and stuff...my mam was a nurse too, I learned a lot from her, she was always helping people and it just seemed like a normal thing to do really...I think that’s why I consider myself to be compassionate now” (P10, Individual Interview, p12).

To summarise, the findings suggested that although *Self-Propensity for Compassion* arose primarily from intrinsic influences, participants perceived that this could be nurtured through education in the home, school and nurse education environments. In particular, an individual’s disposition for compassion was thought to be subject to cultivation, maintaining and further developing *Attributes for Compassion*. The experiences of participants had led them to understand that education, by formal and informal strategies, was an essential step towards socialisation of compassion as a core value within nurses and wider society in general. Appropriate education was therefore considered essential for nurses, in order to ensure that they embraced and perpetuated compassion in their practice. Although participants deemed education to be important, they also highlighted the value of socialisation in the context of the care environment via appropriate *Role Modelling for Compassion*.

5.4.2 Role Modelling for Compassion

The influence of role modelling was noted to be significant, with participants perceiving it to be instrumental in developing and sustaining compassion in the nursing care context. The idea that compassion could be learned and perpetuated by a process of observing it in others, was identified as being an extremely powerful factor in the socialisation processes involved in the professional care context. The notion that positive role modelling was vital for compassion was evident and suggested that learning about compassion in the care context from nurses who exhibited it, was an essential strategy to encourage others to imitate similar behaviours:

“You need a nurse who sets the scene for good practice...a champion on the ward who has the interest of the patients at heart...it would lift the standards for everyone” (P11, Focus Group, Transcript 2, p7).

The findings suggested that positive role modelling, involving explicit demonstration of compassion and associated personal and professional attributes and interactions, was key to sustaining it within the care environment. Following a negative experience involving the way her husband’s challenging behaviour was managed, a participant was clear that demonstrating positive role modelling behaviours for compassion was vital, although she acknowledged that a fundamental baseline for compassion was essential in order to build upon this further:

“You can teach compassion, you can show it, you can show a nurse what compassion is and they will probably learn that way...you can teach it to a certain extent by good practice... there has to be something along the way in them, or why go in to that job” (P8, Individual Interview, p11).

The idea of a cascade effect was evident from the data, an effect where nurses observed and then mirrored the actions and behaviours that they witnessed in others,

thus demonstrating similar interactions across the wider nursing group. Role modelling from nurses who exhibited compassion through their interactions with individuals experiencing care, was considered to be a source of influential socialisation to initiate a positive cascade effect. One participant identified the positive influence a compassionate nurse could have on others, identifying the potential for this to extend to other nurses in the immediate care context:

“I have got a fabulous nurse at my practice, I mean she is absolutely great...it has a knock on effect” (P6, Individual Interview, p19).

Participants also identified that role modelling from nurses who failed to exhibit compassion through their behaviours and interactions, had the potential for a negative cascade effect that could influence compassion in others. In the focus group discussion, participant perceptions of this clearly suggested that negative behaviours and interactions could extend to others, as they may be susceptible to accepting them to be the norm:

P11: This goes back to my comment about the nurses who are coming through the training and seeing different ways of doing things, if you have got a nurse who has been qualified for quite a long time and doesn't see the need for somebody to go up and say 'hello Mr [names husband], how are you this morning' and hold his hand. If I can give you an example; when he [her husband] was moved onto the last ward and it was sort of in the early hours of the morning, there was a nurse there that had previously done bank nurse things, and I did what you would normally do, I leaned over the bed and I got a hold of [name]'s hand and said 'there you are dear, it will be alright', comforting him, and this nurse turned around and said to me 'don't lean over the bed, you're invading his space'.

P2: What!!

P3: Now, that sort of thing is not appropriate.

P2: No.

P11: So if a new nurse had come on and had been with her and learning the ropes, she would have thought that, you know, we don't lean over a patient's bed. So, whoever is in charge of the ward really does need to set the standard for the nurses that are coming in, and listen to new ideas.

P3: Or they learn the wrong things...

I: Aha, what do you mean by that?

P3: Well, because if that nurse is going to teach other nurses that...then it's just going to spread isn't it?
(Focus Group, Transcript 2, p5).

The focus group discussion reinforced the notion that individuals learn from one another, highlighting that negative role modelling in the care context had the potential to impact on the development of others. The role of education and learning in the care context was identified as a powerful strategy to cultivate the nurse's baseline *Self-Propensity for Compassion* and *Attributes for Compassion*. The data suggested that negative experiences of care could affect the individual and profoundly influence their enduring perceptions of compassion:

P11: If you haven't got good training on the clinical skills, well then you are not going to be a good nurse. If you haven't got compassion or can see good role models, then you are not going to be a good nurse. And if you are not a good nurse then you are not going to have a happy ward.

I: Aha. And the person, the patient?

P11: Is going to go home feeling disgruntled...it's the things that go wrong that people remember, it's the remarks that people make, maybe unintentionally, that you remember.

I: Aha.

P2: So it has to be a good all round everything.

(Focus Group, Transcript 2, p11).

Participants perceived that experiences within a negative culture of care could be a catalyst to diminish compassion, leading nurses to accept uncompassionate practices to be the norm. Although it was acknowledged that many nurses may possess pre requisite levels of *Self-Propensity for Compassion* and *Attributes for Compassion*, participants noted that this could be superseded through exposure to negative experiences, thus reinforcing uncompassionate approaches and interactions:

"I think in an awful lot of people, it's something inside them...and I suppose it could get knocked out of you too, if you have bad experiences" (P5, Individual Interview, p16).

Professional socialisation in the care context was deemed to be key to developing and sustaining compassion. The findings suggested that nurses required a baseline level of intrinsic compassion in the first instance, which educational and socialisation strategies aimed to cultivate further. Participants perceived that positive role modelling could nurture compassion in nursing, whilst negative role modelling could hinder it. However, *Leading for Compassion* was identified to be an additional influential factor on compassion.

5.4.3 Leading for Compassion

In further support of positive socialisation for compassion, participants also highlighted the role of effective leadership as a vehicle to support and nurture compassion in nursing. Many participants discussed the role of the Matron or the Nursing Sister in the care context, suggesting that the implementation of appropriate leadership for compassion was integral to sustaining compassion in nursing:

“I think a lot will depend on what the sister in charge of the ward, on what they’re like and if they pick up on how their staff act, you know” (P1, Individual Interview, p14).

A participant drew upon the experiences of an acquaintance with whom she had discussed aspects of compassion following the negative experiences of her husband. This acquaintance was a retired Matron, who suggested that compassion was inspired from effective leadership, which operated within a culture that fostered mutual respect between nursing staff. This ideology had influenced the participant’s perception that effective leadership was important for compassion to flourish, particularly in regard to creating a culture for compassion that was underpinned by team working, positive staff relationships and aspirations to maintain standards:

“I was told [about compassion] by [name], a matron actually, and as things go she was strict, ran a tight ship and the nurses liked her, they respected her” (P8, Individual Interview, p12).

Some participants perceived that leadership went beyond the Matron or Nursing Sister, suggesting that it was also necessary for compassion to emanate from the most senior of staff within the caring organisation. The notion of compassion cascading from the top of the organisation and disseminating throughout was apparent in the data, with participants considering it to be an influential catalyst to inspire other nurses. Approaches which encouraged compassion towards staff, thus promoting compassion towards individuals experiencing care, were thought to be significant:

“I believe it [compassion] comes from the top” (P9, Individual Interview, P15).

Participants suggested that effective leadership to support an appropriate organisational culture of compassion, was a potential factor to influence compassion. In instances where an appropriate culture of compassion was not evident, participants highlighted that effective leadership was vital to facilitate this. A participant discussed her experiences in the outpatient department, where she had felt expedited through the system and treated simply as a task to complete. As a result, she clarified the importance of appropriate leadership as a means to maintain standards and exemplify compassion in the care context:

“I didn’t really see a leader there when I had my appointment in that department [outpatients], there was no clear manager and perhaps that’s what was needed...they need to have effective leadership...someone who’s in support of compassion, who can show them how to act” (P7, Individual Interview, p5).

The notion of leading by example, and creating a nurturing culture for compassion, was an important aspect of participant perceptions. Examples were provided in the data of effective leadership for compassion and as a result, participants were cognisant of the benefits of this to individual experiences of care. The notion of returning to traditional values was suggested as a strategy to reinforce compassion:

“Old fashioned nursing, where the sister was there and you saw everything that was going on...I think that goes for good nursing, and compassion of course” (P11, Focus Group, Transcript 2, p11).

Conversely, the idea of ineffective leadership for compassion was deemed to have potentially detrimental effects. Participants identified that in care contexts where leadership failed to support standards which fostered a culture for compassion, uncompassionate practice had the potential to be accepted as the norm. This was illustrated in the focus group discussion, which highlighted the vital role that nurse leaders had to play in setting standards for compassion and inspiring others to maintain them:

P11: Whoever is in charge of the ward really does need to set the standard for the nurses that are coming in, and listen to new ideas.

P3: Or they learn the wrong things...

I: Aha, what do you mean by that?

P3: Well, because if that nurse is going to teach other nurses that...then it's just going to spread isn't it?

(Focus Group, Transcript 2, p5).

One participant recalled an experience where a Sister had exhibited behaviour that she deemed to be inappropriate. This involved discussing her care without the participant's involvement, which she perceived demeaned her position in the relationship. She suggested this could be imitated by others who might accept this approach to be acceptable:

“A sister in one of the wards stood outside my door and discussed my case loudly in the corridor with a doctor and I wasn’t happy about it. The type of person I am, if I’m not happy, I’ll say. I’m not intimidated or scared to approach staff and say, look, I’m not happy with that. And this is what I did. I called her in and I said: “excuse me, I heard you talking about my case in the corridor and I’m not happy about that”. You know. I really don’t think that should have happened...you don’t want others to think that’s ok” (P3, Individual Interview, p3).

Another participant suggested that less experienced nurses required support to develop appropriate attitudes for compassion, due to her personal experiences with younger nurses who had exhibited negative attitudes towards her. She perceived that more experienced nurses were integral to facilitating this, by implementing strategies to teach and encourage others to demonstrate appropriate approaches to care, thus promoting compassion and fostering positive individual perceptions of it:

“Now I don’t know whether it’s because they have gone in maybe at a certain age and they haven’t got the, the responsibility that the sisters have got so they can be a little bit more abrupt... I sometimes think some of the younger nurses need help with their attitude” (P4, Individual Interview, p19/20).

Clearly, participants perceived the role of effective leadership to be vital to promoting compassion in the care context, by implementing strategies to teach, encourage and support other nurses to perpetuate the attributes and interactions that were deemed to be representative of compassion in nursing.

5.4.4 Category Summary

To summarise, analysis of participant data uncovered a strong underlying theme supporting the concept of appropriate *Socialising for Compassion*, specifically in relation to education, role modelling and leadership. In the first instance, participants perceived that intrinsic *Self-Propensity for Compassion* was an essential requirement for nurses, supporting appropriate *Attributes for Compassion*. Intrinsic influences on these attributes were acknowledged, however, participants also recognised the impact of extrinsic socialisation processes. Participants perceived that further

nurturing by appropriate education, role modelling and leadership was required in order to nurture and sustain compassion in nursing. *Socialising for Compassion* was therefore elicited as an important factor with significant potential to impact on compassion, and ensuing individual perceptions of compassionate or uncompassionate experiences.

Clear links between the categories of *Self Propensity for Compassion*, *Attributes for Compassion* and *Socialising for Compassion* were evident. Within the category of *Socialising for Compassion* there was also a sense of interdependency between the properties of education, role modelling and leadership. In fact, it was clear that these three interdependent properties had the potential to have a cascade effect on one another. One participant articulated this with eloquence, suggesting that students or new staff who had experienced appropriate education to nurture compassion, could be potentially overwhelmed by the negative views of existing staff and be socialised into routines and rituals, which they subsequently accepted to be the norm:

“If you have got somebody who has been qualified for a long time, and is resistant to it [compassion] ...the new ones that are coming in, or newly appointed even...they are going to have a battle royal, they are not going to give way...you are not going to get the best possible care for people coming through because the new ones will give up...they will just blend in” (P11, Focus Group, Transcript 2, p7).

Participants also recognised the potential for specific conditions in the care context to influence compassion, highlighting a range of factors to illustrate this which had been elicited through their personal experiences of care.

5.5 Category 4: Conditions for Compassion

The category *Conditions for Compassion* incorporates the properties of *Resources for Compassion*, *Systems and Processes for Compassion* and *Reciprocity for Compassion* (Figure 15).

Figure 15: *Conditions for Compassion: Properties*

Category:	<i>Conditions for Compassion</i>
Properties:	<i>Resources for Compassion</i> <i>Systems and Processes for Compassion</i> <i>Reciprocity for Compassion</i>

The findings discussed so far have identified that participants perceived nurses to primarily require intrinsic *Self-Propensity for Compassion*, and that compassion was embodied by *Attributes for Compassion*, which were thought to be subject to influence by intrinsic and extrinsic factors. These extrinsic factors related to *Socialising for Compassion*, comprising strategies involving education, role modelling and leading for compassion. Participants highlighted that these three data categories influenced their experiences of a compassionate or uncompassionate encounter, and also contributed to influencing their individual perceptions of compassion. Although some participant experiences were derived from encounters involving both nurses and other health care professionals, participants clearly translated their perceptions of this to compassion within the context of nursing. However, participants were aware of a variety of additional extrinsic conditional factors, which they identified as having the potential to impact on compassion. This involved *Resources for Compassion*, *Systems and Processes for Compassion* and

Reciprocity for Compassion. In the following section each of these category properties are discussed and supported by participant data, with a category summary reiterating key points.

5.5.1 Resources for Compassion

Participant experiences were varied and their narratives reflected encounters of nursing care across a diverse range of environments. As a result of this diversity, it was evident that the care context could influence perceptions of compassion. This primarily related to the issue of human resource ratios, and the impact of this on the nurse's ability to exhibit compassion. In care contexts where human resource ratios were higher, participants perceived that nurses were more enabled to care with compassion. A participant who experienced a prolonged stay in ICCU provided an example of this, illustrating the positive impact of human resource ratios on compassion:

"It's a different world altogether, being in intensive care and then going on to the ward. I mean the nurses were great, I mean bless them they work hard. But it wasn't the same as having like the one on one basically for 24 hours...if I rang for them on intensive care, they were there within like, you know, with a bedpan straight away, on the ward you would maybe have to wait...it's a bit like you're spoiled for care up there [on intensive care]" (P2, Individual Interview, p4).

Another participant was able to identify that experiencing nursing care in her own home within the community setting was more conducive to compassion, as the nurse was more focused on her individual needs and had the capacity to spend more time with her:

"In your own home they notice more things and how they affect you. They've got that many people to see in hospital...but when it's in your own home, yes they've still got other people to see, but they can spend a bit more time with you and consider all the factors that might be affecting you" (P3, Individual Interview, p6).

In care contexts where human resource ratios were lower and workloads inevitably higher, there was a noticeable impact on compassion, significantly influencing participant perceptions as a result. Participants noted that even when nurses may have possessed pre requisite self- propensity and attributes for compassion, their motivation to provide nursing care with compassion was inhibited as a consequence of increased workload, arising from a lack of human resources. The participant who had identified higher human resource ratios in ICCU as a factor to enable compassion, also identified how lower human resource ratios in the ward environment could inhibit it:

“There’s not enough people on the battlefield...there always seems to be a shortage of staff on the ward and it’s not the nurses fault. I think their workload is incredible...I just felt sorry for the staff really. I knew they were doing their best, but it was just the lack of numbers...a big change from having one on one...there’s maybe a couple of nurses on the ward for 12 or 20 patients... I would press the button and it might be 10,15 minutes before somebody came because there wasn’t enough staff available” (P2, Individual Interview, p8).

Another participant supported the notion that lower human resource ratios could inhibit compassion, recognising that this was not specifically due to the nurse’s proclivity for compassion. Rather, it was perceived to be as a result of workload and not having adequate time to practice compassion. The impact of this ensued in nurses making choices about the priorities for care, often resulting in decisions to prioritise technical nursing care interventions with higher importance. Participants acknowledged the emotional impact of having to make such choices, suggesting that when nurses were under pressure it was undoubtedly challenging to demonstrate compassion:

“Some of them are so, so busy and short staffed, and I can understand that sometimes, you know, think oh I haven’t got the time for that, I have got to do this and the buzzers are ringing...that must put a lot of pressure on them and that must

make them sometimes show a bit less compassion...they might be compassionate and understanding, but I think I have got to give them the benefit that at times, they must be stretched so much that it must be very hard to show compassion” (P4, Individual Interview, p13).

High workload pressures and low human resource factors were highlighted as factors with potential to negatively impact on the nurse’s ability to demonstrate the attributes that were considered to be representative of compassion. Although it was appreciated that workload pressures created a potential for such a negative impact, participants still expected to be treated with compassion. One participant, a retired nurse herself, acknowledged the challenges of contemporary nursing, but still concluded that nurses needed to ensure that compassion was integral to all aspects of nursing care practice:

“There was no feedback, facial feedback. There was no sort of eye contact. I mean everything was done properly you know, it was very clinical. Very clinical. There was no empathy... a busy day in a clinic, it must be hard...but I think in nursing you have to rise above that...instead of being very matter of fact” (P5, Individual Interview, p7).

Lack of time was a further factor identified by participants as having a potential inhibitory impact on the nurse’s ability to demonstrate compassion. The issue of time was clearly inter linked with capacity and motivation for compassion. In instances where human resources were low and workloads high, having the time to be compassionate proved challenging, often leading participants to consequently perceive a lack of compassion. A participant remarked that during one of her numerous hospital admission stays, nurses failed to recognise her low mood as they were overwhelmed with workload pressures resulting in less time to observe or notice other issues that may be occurring around them:

“It’s just lack of time. They haven’t got the time to show that [compassion] as much now you know. They’re too busy, they don’t notice as much, if you’re upset or sobbing into your pillow” (P3, Individual Interview, p5.)

Another participant recalled her experience in the outpatient department, where limited time impacted on her experience of compassion, as a result of being expedited through the system. This contributed to her perception that she had been treated as a task to complete:

“They didn’t have the time to be compassionate, all they were interested in was getting the job done, moving me to the next location...like I was just another task to complete” (P7, Individual Interview, p4).

Participants perceived that financial resources were often responsible for high workloads and low human resource ratios, citing budgetary constraints as an influential factor. Participants suggested that these constraints had a direct impact on compassion in nursing and subsequently, their perceptions of the care experience. Clear links were perceived between finances and staffing levels, with participants suggesting that declining staffing levels had a negative impact on compassion:

“It’s all down to money I suppose, cutbacks, staff shortages...if there’s not enough in the pot, what else can we expect I suppose” (P7, Individual Interview, p5).

Overall, participants were aware that nurses often had limited control over the issue of resources, and in most instances, they were simply striving to fulfil the nursing role to the best of their ability. In spite of this, participants were clear in articulating that they perceived adequate human resources were an essential requirement to facilitate compassion in nursing. This suggested that ensuring an appropriate level of funding was an essential requirement to support nursing resources and facilitate

enabling *Conditions for Compassion*. Without this, participants perceived that compassion in nursing could be significantly inhibited:

“There’s no point in chastising a nurse when that nurse doesn’t have the amount of staff that she needs on the ward...you get a very busy nurse and her compassion goes out through the door because she is rushed off her feet. So you’ve got to have the amount of staffing on the ward to give the excellence of care...with compassion” (P11, Focus Group, Transcript 2, p2).

In addition to resources having an impact on compassion, participants perceived that *Systems and Processes for Compassion* also had a significant role to play.

5.5.2 Systems and Processes for Compassion

The findings uncovered a range of conditional factors relating to systems and processes operating within the contemporary care context, which participants perceived had the potential to negatively impact upon compassion. Participants identified that detrimental changes had occurred over time, ensuing in a lack of time for compassion due to workload pressures in the modern day systems of nursing practice. One participant compared nursing care she had received in the past, with care she had observed recently, noting significant differences in the attitudes of nurses and what she perceived to be a declining affinity with the attributes that were required to facilitate compassion:

“About 18 years ago I had a gynae operation and that was a good experience...the care was absolutely fabulous...then 12 years ago I had a funny do...everybody was very gentle with me and very caring, very understanding...but recently I was up at the clinic with a friend...the nurse that she saw was absolutely appalling. I was with her, it wasn’t hearsay, I saw it. There was nothing. And she was a state registered nurse, a staff nurse. There was just no interest whatsoever...I was shocked, I really was...maybe it’s burnout...maybe they haven’t got the time” (P5, Individual Interview, p12).

Participants identified that the utilisation of technology within the care context was also an inhibitory factor, with potential to impact on their experience of compassion.

The data did not suggest that it was the use of technology, per se, as the reason for this perceived lack of compassion. Rather, it was the time taken to use the technology, which could move the focus of care away from the patient, in favour of managing the equipment. A participant described how the nurses caring for her demonstrated competence to operate technological equipment, but simultaneously lacked the time to communicate, make a connection or reassure her:

“Machinery...you know they might know how to programme my dialysis machine, but because of other work pressures they haven’t got the time to sit on your bed now and notice that you’re upset like they used to...with all this technology they know how to work the machine, but they haven’t got the time to sit and talk to you for five minutes. I think that’s really sad...it’s really important because that’s where the real compassion comes in” (P3, Individual Interview, p4).

In areas where human resource ratios were higher such as ICCU, the use of technology was not identified as a factor negatively impacting on compassion. Rather, technology was perceived to be an integral component of care, as nurses appeared to have adequate time to utilise it appropriately, whilst still maintaining a compassionate approach to the individual they were caring for. This suggested that there were clear links between staffing levels and workload as factors which could inhibit compassion:

“I had like sort of four tracheostomies in altogether and different lines, I had lines all over the place, and they would tell me what they were doing, what was going on. You know, it’s a scary place. You’re like lying there and you can just hear this machinery beep, beep, beeping all the time, so they always kept you, let you know what was happening...they were there all the time, they were just brilliant” (P2, Individual Interview, p6).

The issue of achieving targets within the context of caring environments was highlighted as a further factor negatively impacting compassion. Participants indicated that there was potential for nurses to move the focus away from

compassion, in favour of meeting key indicators. This resulted in perceptions that nurses considered targets to be of greater importance than focusing on the individual, often to the detriment of participant experiences of compassion. Although participants were mindful that achieving targets was an issue enforced on nurses by government and organisational driven policy, they suggested that the impact of this on current systems and processes was not always conducive to enabling compassion in the care context. A participant with extensive life experience of nursing care, articulated her belief that the emerging influence of meeting targets had detracted immensely from her individual experiences of care over time:

“They’ve got to put less emphasis on... targets...key indicators and all the rest of it and think more holistically about people. Get the emphasis back on people...the emphasis has got to be put back on patient care...I think a lot of people would prefer to do that, but it’s just what they’re told by the big bosses to do” (P3, Individual Interview, p11).

A further factor regarding inhibitory systems and processes, identified the increasing amount of paperwork that nurses were responsible for completing. Participants perceived that the time taken to complete documentation could detract from the nurse’s ability to spend time with the individual, and was often instrumental in prohibiting the nurse from demonstrating attributes and interactions for compassion. A participant highlighted the impact of paperwork on the nurse’s capacity for compassion, acknowledging that despite many nurses desiring to act with compassion, achieving this was challenging in the contemporary care context:

“There is so much expected of them now and I know they have to do an awful lot, more paperwork...I don’t really think nurses went in to do paperwork, they went in because they have this compassion for nursing and want to help people” (P6, Individual Interview, p13).

Overall, participant data suggested that contemporary nursing systems and processes involved significant conditional factors with the potential to negatively impact on compassion. The issue of time seemed to be affected by the use of technology, increased documentation responsibilities and the ensuing shifting focus away from the individual, inhibiting the nurse's ability to demonstrate compassion. One participant reflected this notion with eloquence:

"I think that's the way the systems have gone, not necessarily them you know...they know how to manage your wound or whatever it is. But you just feel as though they're less interested in you as a person, you feel more like a statistic. That they just want to fix you up and get you out...where historically, I think they had more time to really sit and talk to you...that's as important as the physical healing you know...they're just more hurried now" (P3, Individual Interview, p5).

Participants also identified the notion of reciprocity as a further contributory factor to impact on conditions for compassion.

5.5.3 Reciprocal Interactions for Compassion

Reciprocity, involving mutual levels of respect between agents, was identified as one of the professional attributes which participants deemed to be representative of compassion (Figure 13). Participants were mindful that reciprocity was an attribute required between nurses, individuals experiencing care and the caring organisation itself, manifesting in positive mutual exchanges between nurses and nurse leaders and nurses and individuals experiencing care. As such, reciprocity was a factor identified as having potential to impact on compassion. Participants were cognisant that reciprocal interactions did not only extend from the nurse, they also highlighted the importance of reciprocity emanating from the individual experiencing care. Examples were evident in the data of incidents where individuals experiencing care, did not extend the level of reciprocity that was deemed appropriate by participants as necessary to foster compassion. A participant identified that she perceived herself to

be amenable, but acknowledged that others may not be, suggesting that this could provoke a similar response and lead to negative reciprocal interactions:

“I’m quite an amenable patient and I think that reflects a bit. I mean the nicest nurse in the world might get fed up, some of the people you know, are so awful to the nurses...behaviour breeds behaviour” (P7, Individual Interview, p8).

As a result, participants appeared to be aware that negative reciprocity could have an impact on the subsequent response of the nurse. It was clear that participants perceived that in order for nurses to act with compassion, they should be treated with a degree of reciprocal compassion and respect by the individuals they were caring for. This suggested that the emotional challenges of nursing required some acknowledgement from the individual experiencing care:

“You can’t pour all your compassion endlessly down a well, you’ve got to have job satisfaction or something to make it worthwhile...after all nurses are only human beings and I suppose they would respond” (P1, Individual Interview, p8).

The notion of reciprocity emanating from the individual experiencing care was further highlighted in the data, particularly in relation to individual expectations of the care experience. Participants suggested that in some instances, individuals seemed to have unrealistic expectations of the care experience and this had the potential to impact on reciprocity and the individual’s perception of compassion. A participant identified that he had observed negative reciprocal attitudes towards nurses, despite their attempts to fulfil care requests in a timely and respectful manner:

“There were two other patients, they were a bit grumpy and they were expecting them [the nurses] to jump...I just sort of felt sorry for the staff really. I knew they were doing their best” (P2, Individual Interview, p8).

Another participant identified that she had observed individuals complaining about minor issues such as the food, when in her opinion, the priority for nurses was on providing nursing care. This participant implied that for some individuals experiencing care, there would always be an issue to instigate a complaint due to their personal levels of expectation. This ensued in the potential for negative reciprocal interactions:

“There was one woman who complained because she didn’t like the food, well you’re not in there for cordon bleu, you’re in to be looked after...there are some who are born complainers, it wouldn’t matter what happened they would complain” (P10, Individual Interview, p4).

Participants also perceived that reciprocity from within the caring organisation was an important aspect of cultivating compassion in the nursing care context.

Perceptions of this focused on the notion that it was necessary for nurse leaders within the caring organisation to treat nursing staff with compassion. It was thought that this could nurture compassion in the care context, reinforcing the idea that appropriate leadership strategies were instrumental in contributing to compassion.

Although not explicitly expressed by participants, the idea that nurse educators and nurse mentors may also have a responsibility to treat student nurses with compassion through interactions which lead by example, was implied:

“Well they need to show compassion to their staff, if they don’t how can they expect nurses to show compassion to the people they are caring for” (P7, Individual Interview, p9).

Participants perceived that even those at the highest level within caring organisations were accountable for fostering compassion through reciprocal relationships:

“I believe it [compassion] comes from the top” (P9, Individual Interview, p15).

The suggestion that compassion needed to cascade from the top to the bottom of the organisation, was evident in the data as a strategy to disseminate and embed compassion in practice. Participants felt this could provide a foundation from which to exemplify compassion, encouraging others to reciprocate via mutual interactions that were founded on respect for each agent’s position in the caring relationship.

5.5.4 Category Summary

In summary, the findings highlighted a series of enabling and inhibiting *Conditions for Compassion* which comprised factors relating to resources, systems and processes and reciprocal interactions, which participants perceived had the potential to impact on individual experiences of compassion in the care context. Participants identified that high workloads and low staff resource ratios were instrumental in inhibiting the nurse’s capacity and motivation for compassion, due to impact on the time they had available to engage in compassionate interactions. Although participants recognised the challenges for nurses they still desired nurses to be compassionate, even in the face of budgetary constraints, staff shortages, higher workloads and advancing clinical and technological practices. The notion of reciprocal interactions between nurses, individuals experiencing care and nurse leaders within the caring organisation were also a significant factor with potential to impact on compassion. In circumstances where enabling conditions were noted, participants were more likely to perceive a compassionate experience, in circumstances where inhibiting conditions were noted, participants were more likely to perceive an uncompassionate experience.

5.6 Core Category: Humanising for Compassion

Through in depth analysis of the data, it was apparent that the four category findings discussed so far, had an important role to play in influencing participant perceptions of compassion in nursing. It was evident that participant experiences of issues arising from these data categories, led to the development of their perceptions of the overall experience. This culminated in developing participant's fundamental constructs of compassion, which have been assimilated into the core category *Humanising for Compassion*, the properties of which are depicted in Figure 16.

Figure 16: *Humanising for Compassion: Properties*

Category:	<i>Humanising for Compassion</i>
Properties:	<i>Self-Propensity for Compassion</i>
	<i>Attributes for Compassion</i>
	<i>Socialising for Compassion</i>
	<i>Conditions for Compassion</i>

Data analysis uncovered the core and central concept of compassion to be in relation to perceiving a sense of humanisation, often through small acts of kindness which participants considered acknowledged their position as a human being. This involved treating the individual as a thinking, feeling person with the capacity to contribute to decisions about their care, as opposed to objectifying them and treating them as a task to complete. Participants desired, indeed required, to be humanised throughout their nursing care experiences by the demonstration of *Attributes for Compassion*, which were perceived to be primarily dependent on the nurse's baseline *Self-*

Propensity for Compassion and subject to further cultivation through appropriate *Socialising for Compassion*.

The data highlighted that compassion was often dependent on care contexts which operated within enabling *Conditions for Compassion*, as opposed to inhibiting conditions. The overarching notion of being treated as a human being was at the core of the data, and of fundamental significance to participants. Therefore, this core category explicates the links between the four categories discussed so far. The following discussion draws upon supporting participant quotations to elucidate the fundamental concepts underpinning the essence of *Humanising for Compassion*.

5.6.1 Explicating Links and Relationships Between Categories

The data identified that participants perceived compassion to be fundamentally dependent on the essence of being treated as a human being:

“I think compassion means treating you like a human being” (P1, Individual Interview, p7).

The findings uncovered that participants perceived being treated as a human being to have a significant influence on their subsequent perceptions of the nursing care experience. The data suggested that humanising approaches to care were fundamental to compassion, and in the first instance, relied on *Self-Propensity for Compassion* and *Attributes for Compassion*. The notion that nurses needed to assume an active role in compassion was clear, with the data suggesting that nurses themselves had to be prepared to offer and utilise elements of their own individual self to achieve this. Acknowledging a sense of shared humanity with others was central to this:

“Compassion...it’s much more than feeling sorry for someone, it’s about nurses giving something of themselves to their patient- their time, their patience, their ability to listen and respond with a caring and humane approach, it’s basic stuff really like showing kindness, it’s about treating people like human beings...that has to come from within the individual nurse” (P7, Individual Interview, p1).

The data also highlighted the importance of nurses demonstrating professional attributes and interactions for compassion, which had the potential to enhance perceptions of humanisation. This involved enabling the individual to perceive a sense of inclusion in the care experience by demonstrating behaviours which actively facilitated choice and control:

“I think compassion means... treating you like a reasonably intelligent person and involving you in some instance with your treatment and your care” (P1, Individual Interview, p7).

This level of inclusive involvement was perceived to be an essential requirement for humanisation, promoting a sense of active participation in the care experience, rather than passivity and objectification of the individual experiencing care. The notion of recognising the individuality of the person was core to this, and the data suggested that the development of appropriate relationships which fostered mutual respect were essential to facilitate this:

“Compassion...being involved and being treated like an individual, a human being in fact... it’s about relationships and mutual respect” (P7, Individual Interview, p1).

“Compassion for me is just seeing a human being there... you’re there to engage in a relationship with that other person” (P9, Individual Interview, p18).

When participants failed to perceive a sense of inclusion, and individual choice and control was not actively facilitated, the notion of humanisation failed to become apparent. In circumstances where appropriate relationships built on mutual respect

did not evolve, participants subsequently perceived a sense of exclusion. This prevented them from assuming an active role in the care partnership, and as a result, there was an emerging sense of dehumanisation. A participant who experienced a negative encounter in an outpatient department illustrated this effectively, contrasting the nurse's failure to demonstrate compassion with the consultant doctor's ability to demonstrate compassion. This experience highlighted the importance of attributes and interactions for compassion, within a relationship that cultivated compassion and humanisation of the person:

*"The nurse called me into a room to do my blood pressure, she wasn't going to close the door and that meant that everyone in the waiting room could see what was going on, so I asked if I could have the door closed. She glared at me before closing the door, she made me feel like I was causing a nuisance really...she did communicate with me but I found her a little patronising, she was speaking loud and slowly as if I was stupid or something. There was just something not quite right, I can't put my finger on it... it was just a feeling that I had that she was just acting a bit like a robot, she wasn't communicating **with** me, it was more like she was communicating **at** me...there was little in the way of an individual approach. I really just felt like I was insignificant and a little bit worthless...when this was over I went to see the consultant...what a difference, he was welcoming and friendly, he shook my hand, greeted me by my name and made me feel at ease. He asked me to tell him what had been happening with my heart and waited patiently to hear my story. I really felt like he was listening to me, involving me, treating me like an intelligent human being... I was astonished by the difference" (P7, Individual Interview, p3).*

The data suggested that dehumanisation of the person could be further compounded by judgemental attitudes and an ensuing failure to facilitate an inclusive approach to care. When participants perceived that nurses assumed a judgemental approach, they sensed a level of dehumanisation. A participant described how her mother had attended Accident and Emergency on several occasions, but each time was discharged due to subjective judgements made about her presenting state of sobriety. This ensued in a lack of compassion for the individual as a human being, denying her appropriate care as a result of what she perceived to be inherent prejudices:

“She’d been up and down to hospital with heart failure, she didn’t drink for the last year, but they didn’t admit her because they smelled alcohol on her breath. So that was her, the neglect seen with her...there was a lot of instances like that. I didn’t actually see a lot of compassion... These are the things that make it hard when you lose somebody, the lack of care, the lack of considering them to be a worthwhile human being...all because they thought she was a drinker” (P9, Individual Interview, p4).

The notion of nurses knowing and individualising the person was also apparent from the findings. The data suggested that participants’ underlying desire for humanisation was often dependent on this and in fact, knowing the person was considered to be a vital means to prevent the individual being objectified. Participants highlighted that when nurses had knowledge of the person and their condition, this had the potential to facilitate attributes and interactions for compassion, thus promoting a sense of humanisation. A participant described issues with the care of her husband who had dementia, highlighting the failure of nurses to recognise his pain or distress. As a result of these negative experiences, she was clear in stating that nurses required knowledge and understanding of the person they were caring for, in order to ensure their individual needs were met:

“I’m going back to dementia...one of the things they need to know, is they need to know all about the person as a person... they need to understand the illness. If they don’t understand the illness, they’re not going to be able to communicate with the person...whatever the illness is, they’ve got to understand about the person first, before they look at the illness, you’ve got to know about that person and treat the person first and the illness second... to be part of their world really. You can’t expect the person with Alzheimer’s to be part of your world, you have got to go into theirs” (P11, Focus Group, Transcript 2, p1).

The importance of acknowledging the uniqueness of the individual was evident in the data. Participants perceived that knowing the person at a level which acknowledged and appreciated their individuality was essential for humanisation. Rather than homogenisation, participants desired individualisation, a significant

factor contributing to their perceptions of humanisation. A participant identified the challenges for nurses caring for her husband who had dementia, illustrating how an individual approach from care home staff was instrumental in achieving a compassionate and human approach:

“He can be a difficult man...but the care home know him well, they manage him very well...I know that they are very good with him, excellent care that he gets, excellent compassion, they are very compassionate. Many a time they will sit with him to calm him down, talking to him...it makes him happy to have someone to speak with him, he’s a talker and he likes to talk to people, they know that about him” (P8, Individual Interview, p7).

In order for nurses to demonstrate attributes for compassion and facilitate a sense of humanisation for participants, the data suggested that intrinsic self-propensity was a fundamental requisite. This was acknowledged through participants referring to compassion as being *“within”* (P7, Individual Interview, p1) the individual or *“inbred”* (P6, Individual Interview, p17). Participants also noted that appropriate socialisation had a critical role to play in nurturing self-propensity further. The data highlighted that effective educational strategies were a vital mechanism to promote humanisation of the person, and could be achieved by ensuring that nurses focused on the individual. The notion of role modelling was also apparent in the data. In environments where the individual experiencing care was not acknowledged as a person by the nurse who was caring for them, it was perceived that there was potential for this practice to *“spread”* (P3, Focus Group, Transcript 2, p5). Effective leadership was therefore deemed to be essential to instil appropriate values across the care context to ensure that nurses appreciated the need to *“see... people as humans”* (P3, Individual Interview, p10).

Participants perceived that enabling conditions for compassion were required to facilitate humanisation. Data highlighted that systems and processes such as the use of technology, increasing levels of documentation and the need to meet targets were potential inhibitory conditions for compassion. In care contexts where these conditions took precedence, participants perceived that there was potential to dehumanise the individual, as the focus of care was shifted away from the person, objectifying them in favour of completing tasks:

“They’ve just got too much other paperwork to do. And it’s sad. I think they know how to work all the machines, but they’re losing the human touch...it’s lack of time and the emphasis too much on paperwork and standards now. Which is ironic when you hear so many bad stories. Targets, you know; I think there’s too much emphasis on that, rather than you know, seeing people as humans” (P3, Individual Interview, p10).

This potential for dehumanisation was also apparent in care contexts where human resource ratios were perceived to be low, and workloads subsequently higher.

Participants identified a link between low human resource ratios and nurses having adequate time to practice with compassion or humanise the individual. This was compounded by the challenges of simultaneously using technology, completing documentation and operating within a context that may have been focused on meeting targets. Thus, there was potential for nurses to simply approach the situation with the aim of getting on with the task in hand, resulting in participant perceptions of being objectified:

“They just didn’t have the time, they were so busy...there didn’t seem enough of them...I felt like I was treated like a piece of meat, just another job to do...not like a real person at all” (P7, Individual Interview, p3).

Issues related to reciprocal interactions were also noted to have potential to impact on humanisation, particularly when individuals experiencing care, and caring

organisations themselves, did not extend reciprocal compassion to nurses. Participants perceived that “*behaviour breeds behaviour*” (P7, Individual Interview, p8), and believed that when nurse leaders failed to show compassion to their staff, this could inhibit replication of it to others. However, the findings uncovered evidence of nurses who were able to maintain compassion through caring practices which humanised the person, despite the presence of potential inhibitory conditional factors. These particular nurses were often in the minority but nevertheless, participants described them as having the ability to demonstrate compassion even when faced with low human resource ratios, high workloads and the challenges of operating within contemporary nursing systems and processes. These nurses were highlighted for their motivation to go above and beyond, attending to “*the little extra bits*” (P1, Individual Interview, p24). Data analysis suggested that this was potentially derived from an enhanced intrinsic self-propensity, enabling the nurse to prioritise making connections and developing relationships with individuals in need:

“Because of other work pressures, they haven’t got time to sit on the end of your bed now and notice if you’re upset like they used to... but there was this particular male nurse...I’d just had some bad news about a condition that I’d had and I was visibly upset and he noticed and he sat there for a good 20 minutes holding my hand, talking to me... That, to me, it’s sort of like, it’s really getting into somebody’s psyche, tuning into people” (P3, Individual Interview, p4).

Overall, the significance of being treated as a person was at the heart of what participants perceived compassion to involve. Experiencing nursing care which acknowledged the individual as a person, and their position as a human being, was of fundamental significance to the research findings. Perceiving a sense of humanisation from the interactions which ensued between nurses and the individuals they were caring for was vital. This was facilitated through positive interactions, which placed the person at the very centre of the care experience. The following

participant experience provides a clear and insightful illustration of this, highlighting the vital need to acknowledge humanity:

“The nurses were busy, they just didn’t seem interested in me as a person or an individual...I was simply a task to do and made me feel like I was treated like a piece of meat in a cattle market. The department was just like a conveyer belt, herding you from one place to the next...maybe they were just too busy, but that to me isn’t an excuse...there’s no excuse for treating you like an object, making you feel worthless and devaluing your humanity...the experience I had was simply devoid of what I would consider as compassionate care...I wasn’t a human to them, I wasn’t a person, I was invisible” (P7, Additional Interview, p1).

5.6.2 Category Summary

In summary, analysis of the data revealed that the key concept underpinning what participants perceived compassion to involve, was fundamentally dependent on experiences of being humanised or dehumanised. The data indicated that participants perceived that compassionate experiences were associated with humanising approaches to care, whilst uncompassionate experiences were associated with dehumanising approaches to care. Clear interdependent links were noted across the four major categories and involved factors related to *Self Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion* and *Conditions for Compassion*. Equilibrium of these factors could contribute to humanising approaches, whilst disequilibrium could contribute to dehumanising approaches. Clearly, it was not as straightforward as this. In fact, the data suggested that there was a complex interplay between the data categories in relation to how they interacted to influence participant perceptions of compassion. However, what was apparent from the data was that, ultimately, participants regarded humanising or dehumanising experiences of nursing care to be pivotal in fundamentally influencing their perceptions of compassion.

5.7 Advancing Conceptualisation of the Findings

As discussed in Chapter 4, engaging in reflexivity to advance conceptualisation of the data categories led me to progress analysis of the findings further. A conceptual mapping exercise (Appendix 19) supported this process and was instrumental in contributing to the construction of the grounded theory that is presented in Chapter 6.

5.7.1 The Five Elements of Compassion

Compassion was perceived by participants to be founded on five key elements which related to *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. These elements of compassion are briefly outlined below to clarify their relationship to the data categories that were presented earlier in this chapter and are discussed in detail in the following chapter.

Character for Compassion- this involves the nurse's predisposition and proclivity for compassion. Character arises primarily from intrinsic personality factors that manifest in *Self-Propensity for Compassion* and is exhibited through *Personal Attributes for Compassion*.

Competence for Compassion- this involves the nurse's ability to demonstrate compassion. Competence arises primarily from intrinsic aspects of *Self-Propensity for Compassion*, but is additionally subject to further cultivation by *Socialising for Compassion* which includes education, role modelling and leadership.

Motivation for Compassion- this involves the nurse's enthusiasm and desire to implement compassion. Motivation arises to some extent from *Self-Propensity for Compassion* but is also influenced by *Socialising for Compassion*. Motivation can

also be influenced by *Conditions for Compassion*, which can exert enabling or inhibitory effects on motivation.

Connecting for Compassion- this involves establishing relationships which are founded on appreciating a sense of shared humanity between the nurse and the individual experiencing care. The ability to connect arises primarily from *Self-Propensity for Compassion* and is exhibited through *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion*.

Action for Compassion-this involves the nurse taking positive action to implement compassion through humanising approaches to care. Action for compassion is dependent on the equilibrium of character, competence, motivation and connecting for compassion. It is demonstrated through *Personal Attributes for Compassion*, *Professional Attributes and Interactions for Compassion* and fundamentally facilitates *Humanising for Compassion*. However, it is also subject to influence by *Socialising for Compassion* and *Conditions for Compassion*.

5.7.2 The Principal Dimensions of Compassion

In addition to the elements of compassion outlined above, three overarching dimensions were also identified to be of emerging importance. These principal dimensions of compassion were associated with *Self*, *Interactions with Others* and *Situational Contexts*. These concepts are briefly outlined below to clarify links to the data categories and the five elements presented earlier and are also discussed in further detail in the following chapter.

Self- The concept of *Self* emerges in the first instance from the nurse's *Self-Propensity for Compassion*, which arises from biological factors associated with

disposition and personality. This self-propensity is reflected through *Attributes for Compassion*, which involve *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion*. *Self* is fundamentally underpinned by *Character for Compassion*.

Interactions with Others- *Self* is subject to nurturing through *Interactions with Others*. Such interactions arise from social experiences encountered through *Socialising for Compassion* via education in the home, school, formal nurse education and care contexts, and through *Conditions for Compassion* via reciprocal interactions between nurses, nurse leaders and individuals experiencing care. These social experiences impact on psychological factors to influence and shape *Self*, and are subsequently demonstrated through *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion* which occur between nurses and the individuals for whom they are caring. *Interactions with Others* contribute to developing the nurse's *Competence for Compassion* and *Motivation for Compassion*, subsequently supporting *Connecting for Compassion* and *Action for Compassion*.

Situational Contexts- The *Situational Contexts* within which nurses' function have potential to impact on *Self*. In circumstances where there are enabling *Conditions for Compassion*, *Self* has the potential to flourish and support nurses to exhibit compassion in practice through humanising approaches to nursing care. Conversely, in circumstances where there are inhibiting *Conditions for Compassion*, *Self* has the potential to wane and impede the nurse's capacity to exhibit compassion in practice, thus ensuing in dehumanising approaches to nursing care. Socio-contextual factors arising from *Resources for Compassion* and *Systems and Processes for Compassion*

in the care context, therefore have potential to influence psychological factors and impact *Self*. In turn, this has the potential to impact on *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*.

The principles of nature and nurture were noted to be of significant influence to the findings. Rather than competing against one another, nature and nurture seemed to complement one another through a complex interdependent relationship between biological, psychological and socio-contextual factors. This complex relationship implicitly influenced participant perceptions of compassion in nursing, suggesting that compassion in nursing could only be more fully understood through a biopsychosocial perspective. This perspective will be discussed in more detail in the following chapter.

5.8 Chapter Conclusion

This chapter has presented the findings from my doctoral research, which represent a complex and multi-dimensional insight into compassion in nursing. The study aimed to explore the primary research question:

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

The intent of the research was to investigate what participants perceived compassion to involve and explore how their individual experiences of nursing care had contributed to developing these perceptions. The insight gained from the research

has therefore been derived directly from participant perceptions of these personal and unique experiences of care, and is grounded in the data that was collected and analysed throughout my research journey. In order to ensure that the participant voice was heard, the chapter did not draw on extant literature, rather, the discussion was simply supported by direct participant quotations.

Four major categories and a core category were presented relating to *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and *Humanising for Compassion*. It was clear from the findings that compassion arose from a complex interplay between these data categories, which incorporated influences from both intrinsic and extrinsic factors. The notion that nature and nurture interacted together, in a highly complex and interdependent way, was evident. The fundamental basis of what compassion involved was highlighted by participants as being dependent on their perceptions of being humanised or dehumanised. When participants sensed they were humanised, they were more likely to perceive the experience as compassionate. Conversely, when participants sensed they were dehumanised, they were more likely to perceive the experience as uncompassionate. The findings suggested that equilibrium of the categories contributed to promoting perceptions of humanisation, whilst disequilibrium of the categories contributed to promoting perceptions of dehumanisation.

The data categories were conceptually advanced and *The Five Elements of Compassion* were briefly introduced, eliciting what participants perceived compassion to involve. In addition, *The Principal Dimensions of Compassion* were

also briefly outlined to identify additional concepts of emerging importance to compassion. Identification of these elements and dimensions provided the basis from which the grounded theory that is presented in Chapter 6 was constructed. This grounded theory is presented in the form of a model for compassion, providing a theoretical representation of the research findings to illustrate the complex nature of what participants perceived compassion to involve.

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Chapter 6: Discussing the Findings and Generating New Insights into Compassion

6.1 Chapter Introduction

The previous chapter presented the findings from the research, identifying the data categories of *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and *Humanising for Compassion*. Following this, five elements of compassion were briefly introduced to represent what participants perceived compassion to involve, uncovered through reflexivity to advance conceptualisation of the data categories. These elements related to *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. Additional concepts of emerging importance were also briefly introduced as principal dimensions of compassion. These dimensions related to *Self*, *Interactions with Others* and *Situational Contexts*. The notion that nature and nurture complemented one another, rather than competed against one another, was also suggested. This introduced the assertion that compassion could only be more fully understood through a biopsychosocial lens, which takes into account biological, psychological and socio-contextual factors.

This chapter presents a comprehensive, analytical discussion to explore the findings in more depth. This involves eliciting links with existing knowledge and clarifying new insights from the data that have emerged to further inform compassion in the context of nursing. In the first instance, the primary research question and objectives are revisited to set the context for the discussion that ensues. A summary of the research findings is provided, reiterating key points and introducing theoretical

concepts of relevance to compassion within the context of nursing. The discussion that follows, provides a critical exploration of *The Five Elements of Compassion* identified earlier, after which the propositional grounded theory that was constructed from the research is presented. This incorporates *The Principal Dimensions of Compassion* that were briefly introduced in Chapter 5 and is presented in the form of a model for compassion. The originality of the model is discussed throughout the chapter within the context of the findings, existing knowledge base and the underpinning theoretical influences of the thesis. Implications for practice emerge as the discussion progresses and these are addressed with a series of recommendations for future practice and research. The chapter concludes by considering the limitations of the research that is presented in this thesis. Throughout the chapter, the discussion is supported by a range of evidence that was explored in the literature review presented in Chapter 2. In addition to this, commensurate with the evolving and dynamic nature of reviewing the literature in grounded theory research (Charmaz, 2014), some additional evidence is also drawn upon to support the discussion that ensues.

6.2 Reiterating the Research Question and Objectives

In order to provide context for the discussion that follows, the research question and objectives introduced in Chapter 1 are reiterated below.

Research Question:

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

Research Objectives:

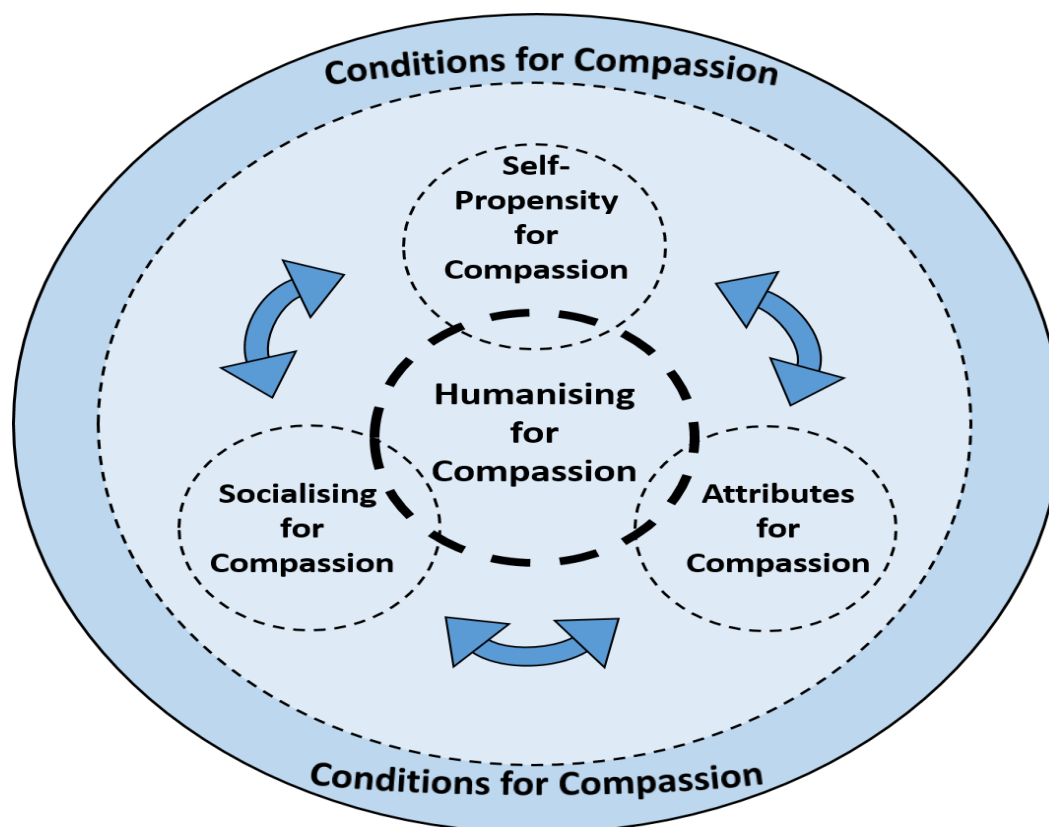
- To explore individual experiences of care to elicit perceptions of what compassion involves.
- To uncover particular nursing care activities, behaviours, qualities or characteristics that may be perceived to be compassionate.
- To explore the potential for contexts and environments of care to influence experiences of compassion.
- To develop a propositional grounded theory which offers an original contribution to understanding compassion in nursing.

From this point in the thesis, the term ‘participant’ is replaced by the term ‘individual’, in order to afford clarity to exploring the findings in relation to the primary focus of the research question.

6.3 Summarising the Key Research Findings

The research findings presented in Chapter 5 identified four data categories relating to *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and a core category relating to *Humanising for Compassion*. It was evident that there was a complex interdependent relationship between the data categories, with each category having potential to influence another. The diagram below illustrates an assimilation of the data categories and the following commentary provides a detailed discussion to explore this further (Figure 17).

Figure 17: Assimilating the Categories of the Research Findings



Assimilation of the data categories into a diagrammatic reconstruction to collectively represent participant perceptions of compassion in nursing provides further clarity to the findings. The diagram illustrates that within the context of nursing, compassion was perceived to be dependent on a series of interrelated and somewhat progressive elements, which had the potential to influence ensuing individual experiences of it. The notion of humanising the individual was at the core of the research findings, representing what fundamentally embodies compassion within the context of nursing.

In order to facilitate positive experiences of compassion in nursing, nurses primarily required a *Self-Propensity for Compassion*. This self-propensity incorporated an

Intrinsic Disposition for Compassion and an *Intrinsic Motivation to Care for Others*.

This was underpinned by a character that had inherent competence for compassion and which motivated nurses to enter the profession due to a desire to care for others.

This was a pre requisite that was required as a baseline foundation from which to further nurture competence for compassion. Personality was a key characteristic of self-propensity, manifesting in *Attributes for Compassion* which ensued in particular *Personal Attributes for Compassion* and *Professional Attributes and Interactions for Compassion*. Personal attributes included patience, kindness and attentiveness (Figure 12), whilst professional attributes and interactions included developing positive relationships, partnership working and negotiation (Figure 13). These attributes supported the nurse to connect with the individuals for whom they were caring and implement action for compassion. They were dependant to some extent on intrinsic characteristics arising from self-propensity, however, they were also subject to influence from extrinsic factors.

The influence of extrinsic factors related to *Socialising for Compassion* and involved *Education for Compassion*, *Role Modelling for Compassion* and *Leading for Compassion*. Education involved learning about compassion in the early years and in the formal nurse education arena, role modelling involved learning about compassion from other nurses in the care context, whilst leading involved the influence of nurse leaders on the organisational culture of care. These socialisation strategies were essential to nurture intrinsic *Self-Propensity for Compassion* and *Attributes for Compassion* further, supporting the nurse to develop advancing levels of competence and motivation for compassion.

It was acknowledged that nurses operated within specific conditions in the context of the caring environment. These *Conditions for Compassion* in the care context could influence the nurse's capacity and motivation for compassion, and the ensuing actions for compassion that they implemented with the individuals for whom they were caring. This involved *Resources for Compassion*, *Systems and Processes for Compassion* and *Reciprocal Interactions for Compassion*. Resources included staffing levels and workload, systems and processes included technical tasks and documentation, whilst reciprocal interactions included mutual exchanges between, nurses, nurse leaders and individuals experiencing care. The nurse's capacity and motivation for compassion could be impacted by this range of conditions, specifically in relation to whether they were inhibitory or enabling conditions for compassion.

When conditions were inhibitory, for example in the context of low staffing levels and high workloads, this could influence the prioritisation of care interventions and lead to the focus being on technical tasks, rather than connecting with the individual at a human level. This inhibitory effect could be impacted further by negative reciprocal exchanges between nurses, nurse leaders and individuals experiencing care, which could exert influence on the nurse's response and impede compassion. When conditions were enabling, for example in the context of higher staffing levels and lower workloads, nurses were more able to connect with the individual at a human level, in addition to having the capacity to complete technical tasks. Moreover, enabling conditions for compassion could also be influenced by positive reciprocal exchanges between nurses, nurse leaders and individual experiencing care.

In circumstances where there was equilibrium of the data categories *Self-Propensity for Compassion*, *Attributes for Compassion* and *Socialising for Compassion* within the context of enabling *Conditions for Compassion*, compassion could be enabled by nursing care approaches which humanised the individual. In circumstances where there was disequilibrium of the data categories *Self-Propensity for Compassion*, *Attributes for Compassion* and *Socialising for Compassion* within the context of inhibitory *Conditions for Compassion*, compassion could be impeded by nursing care approaches which dehumanised the individual. Humanising approaches involved treating the individual as a human being and respecting their ability to think, feel and participate in their nursing care experience. Dehumanising approaches involved objectifying the individual and failing to acknowledge their position as a human being, leading to nursing care which regarded them merely as a task to complete. The research findings uncovered a complex interplay between the categories that emerged from data analysis. This involved a distinct interdependent relationship between *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and *Humanising for Compassion*.

6.4 The Five Elements of Compassion

As discussed in Chapter 4, reflexivity and conceptual mapping (Appendix 19) advanced conceptualisation of the data categories. This ensued in the identification of five elements of compassion, briefly introduced in Chapter 5, to represent what individuals perceived compassion to involve. These elements related to *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. The discussion that follows

explores each element in turn to explicate relevance to the findings from this study and the existing literature that currently informs compassion. Throughout the discussion some 'in vivo' phrases are drawn from the data that was presented in the findings chapter to afford appreciation to the individual voice. The original contribution to knowledge, and the new insight that these five elements offer to understanding compassion, is elucidated within the context of nursing.

6.4.1 Character for Compassion

The findings identified that, in the first instance, nurses required self-propensity for compassion. This was apparent in nurses whose character exhibited a fundamental proclivity for compassion, which individuals considered to be primarily influenced by biological factors. Research in the psychology field identifies that innate factors influence the degree to which a person inherits universal attributional traits, ensuing in differences between people due to their unique position on the factor model continuum of human personality (McCrae and Costa, 1987, 1997). In addition to this, Baron-Cohen (2012) identifies that people lie on an empathy continuum, where those at the lower end lack empathy and those at the higher end exhibit remarkable empathy. However, the notion that biological factors can influence compassion specifically, is a notion only briefly suggested in a recent empirical research study to explore perceptions of compassion (Kneafsey *et al.*, 2016). Despite identification of this influencing factor, the research of Kneafsey *et al.* (2016) originates from a collective perspective, subsequently blending the views of professionals and individuals who have experienced care into one single representation of compassion. My findings advance this knowledge, identifying exclusively from the views of individuals who have experienced nursing care, that intrinsic biological factors are

perceived to influence the nurse's self-propensity and intrinsic dispositional proclivity for compassion.

In my study, character for compassion was exemplified by personal attributes and the ensuing interactions that occurred between nurses and the individuals for whom they were caring. Individuals identified a wide range of personal attributes that were deemed to be representative of compassion, which included attributes such as patience, kindness, attentiveness, empathy and effective communication (Figure 12). Previous empirical research to explore perceptions of compassion has also identified a range of personal attributes to be indicative of compassion, although the range of attributes identified is significantly less extensive than those elicited from my findings. Other previous research has identified attributes such as understanding (Day, 2015), attentiveness (Krett, 2011; Van Der Cingel, 2011), effective communication (Skaff *et al.*, 2003; Sanghavi, 2006; Bramley and Matiti, 2014; Kneafsey *et al.*, 2016; Sinclair *et al.*, 2016 a) and empathy (Burhans and Alligood, 2010; Lown, Rosen and Martilla, 2011). However, much of this research emanated from professional or collective perspectives, with limited consideration of the attributes that individuals who have experienced care themselves, perceived to be indicative of compassion.

Research that has exclusively explored the perceptions of individuals who have experienced care has largely arisen from the health care systems of the USA and Canada, with only the research of Bramley and Matiti (2014) exploring individual perceptions of compassion within a UK nursing context. Despite these potential

cultural differences, this range of research identifies that particular attributes are deemed to be specifically associated with compassion. This is also evident in the psychology research arena, where attributes that are synonymous with pro social traits of human personality are considered to be associated with compassion (McCrae and Costa, 1987, 1997; Ashton and Lee, 2008; Williams, Dean and Williams, 2009). My findings advance understanding of this in the context of nursing, identifying that a wide range of attributes are perceived to be associated with compassion, providing a more comprehensive insight that has implications for nursing practice.

A unique insight into character for compassion was elicited from my findings, advancing the originality of my research and the evidence base that currently informs compassion. This new insight identified that for undetermined reasons, some nurses seemed to possess an enhanced dispositional character for compassion. This was exemplified in nurses who had the ability to go above and beyond, attending to the “*little extra bits*”, often through small acts of kindness via ‘momentary vignettes’ for compassion. Examples of this included nurses using touch to provide reassurance throughout anxiety provoking procedures, or taking the time to engage with the individual at a human level to notice their low mood during routine nursing interventions. Although other commentators have identified the value of seemingly small and insignificant interventions to influence perceptions of compassion (Perry, 2009 a), the notion that such an approach arises from an enhanced disposition as a noteworthy aspect of compassion, has not been fully elucidated previously.

Although Reimer's discursive commentary (2013, 2015) refers to 'moments' of compassion as a means to overcome compassion fatigue, across the empirical research conducted to date there is no suggestion that individuals experiencing care regard 'momentary vignettes' to be a significant aspect of compassion itself. In my findings, an enhanced disposition for compassion, exhibited through the implementation of such vignettes, was seen to set these particular nurses apart as individuals perceived them to be different from others. Although it was beyond the scope of my study to fully determine the reasons why some nurses had this enhanced ability, the findings suggested that it may be as a result of the nurse's ability to recognise the needs of others (Ashton and Lee, 2008; Williams, Dean and Williams, 2009), enabling them to see things from the individual's perspective (Mead, 1934) and as a result, adopt approaches to care which fundamentally humanised them (Galvin and Todres, 2013).

Commentators suggest that the ability to recognise the needs of others primarily involves emotional intelligence (Buchanan-Barker, 2004; Dewar, 2013), whilst implementation of appropriate compassionate action may be dependent on the nurse's capacity for self-regulation (Baumeister and Vohs, 2007; Frie, 2013; Hewitt-Taylor, 2015), personal levels of self-agency (Giddens, 1986; Vallacher and Wegner, 1986; Archer, 1996; Whittle and Mueller, 2016), self-efficacy (Choi *et al.*, 2016) and compassion resilience (Frederickson and Branigan, 2005; Potter, Pion and Gentry, 2015). Although offering some plausible insight into the notion of an enhanced disposition for compassion, these presumptive explanations are merely propositional and as such, identify the need for further exploration through additional research.

The findings of my study revealed that a character for compassion was an essential baseline foundation of competence from which to further cultivate compassion in nursing, a claim that has been suggested by others. However, much of the work from other commentators in relation to this issue arises from the professional perspective (Aiken *et al.*, 2014; Bray *et al.*, 2014; Richardson, Percy and Hughes, 2015), with only one study identifying this claim exclusively from the individual perspective of those who have experienced care (Bramley and Matiti, 2014). My findings advance this claim further, identifying that individuals in my study clearly perceived that a character for compassion was a fundamental pre requisite for nurses.

6.4.2 Competence for Compassion

Although the research findings identified that a character for compassion was required to provide a baseline level of competence for compassion, individuals also asserted that this required further nurturing. Socialisation strategies to build upon intrinsic character and disposition were deemed to be required via appropriate educational experiences in the home, school, nurse education and care contexts. The notion that developing competence for compassion began in the early years was apparent and evident in claims that this ensued from childhood experiences, with individuals stating that they had personally learned about compassion via this approach themselves.

Childhood and early years experiences are instrumental in reinforcing learning, shaping psychological factors associated with human character and personality as a result of exposure to social and environmental factors (Watson and Rayner, 1920; Baccus, Baldwin and Packer, 2004; Pervin and Cervone, 2010; McCrae, 2011; Price-Mitchell, 2013). This is apparent in a range of research which suggests that

developing competence for compassion in childhood, promotes competence for compassion in adulthood (Johansson, 2008; Sanders, 2010; Layous *et al.*, 2012; Price-Mitchell, 2015). Although this claim is supported by research into compassion within the realms of the psychology research arena, my findings generate new insights into the perceptions of individuals experiencing care within the context of nursing. Learning about compassion in childhood was regarded as a vital means to foster compassion in nurses in the adult years, evidenced by statements which indicated it to be the primary reason why individuals in my study considered themselves to be compassionate in adulthood. These childhood learning experiences had contributed to the individual's social reality of compassion (Berger and Luckman, 1966), and were translated to their perceptions of compassion in the nursing context to suggest that early years education was vital in the social world, particularly for people who may elect to pursue a nursing career.

There is evidence to suggest that exposure to early years experiences of compassion has declined, as society has increasingly adopted a focus on individualist (O'Shea, 2011), rather than collectivist, social values (Thake, 2008; Seligman *et al.*, 2009). This has affected social learning about traditional values such as compassion (Armstrong, 2011), inevitably influencing nurses as products of society themselves (Mead, 1934; Berger and Luckman 1966; Blumer, 1969), thus promoting perceptions of an individualist, rather than a collectivist 'societal self' (Lalljee, 1996). Individualist approaches to social life have contributed to a consumerist effect (Ritzer, 2004), which has also influenced nursing practice through the implementation of approaches that focus on quality and standardisation, often to the

detriment of focusing on people (Sturgeon, 2010). Throughout my research findings this was apparent, with individuals identifying examples of experiencing dehumanising approaches to care, often as a result of the nurse failing to focus on the person as an individual.

Individuals in my study acknowledged that early years education was therefore vital for compassion, a claim that is evident in other commentaries which acknowledge that education can promote pro social traits and equip young people with an internal moral compass (Hollingshead *et al.*, 2009; Wolpow *et al.*, 2011; Peterson *et al.*, 2014; Price-Mitchell, 2015) that enables them to self-regulate for compassionate action (Cohen and Morse, 2014; Covington, 2015). The value of investing in human capital (human attributes and capacities) through educational interactions to develop social capital (collective norms and values) is recognised as an essential means to support socially desired outcomes, influencing people to assume the collective values of the social group (Schultz, 1972; Coleman, 1988; Putnam, 1993, 2000). Being exposed to compassion in the early years was therefore perceived to be an important catalyst to promote collective values for compassion in society, supporting nurses to exhibit a baseline ‘potential’ for compassion within the context of nursing, in the adult years.

The findings highlighted that experiences in the formal nurse education environment were an additional strategy to cultivate competence for compassion. Nurse education was considered to be of the utmost importance, with individuals purporting that nurses needed to learn from real life case experiences in order to develop an insight

into the individual perspective. Enabling people to see things from the individual's perspective (Mead, 1934) promotes recognition of shared human values (Ayala, 2010; Floyd, 2015) and in nurse education, this is regarded as integral to nurturing competence for pro social traits and behaviours (Hoover, 2002; Brunero, Lamont and Coates, 2010; Herbst, Swengross and Kinney, 2010; Dewar and Mackay, 2010).

Although there is some debate about whether compassion is innate or can be taught (Wood, 2014; Richardson, Percy and Hughes, 2015; Kneafsey *et al.*, 2016; Sinclair *et al.*, 2016 b), there is evidence to suggest that competence for compassion can be cultivated in the context of nursing through formal educational strategies (Dewar and Mackay, 2010; Adamson and Dewar, 2015; Tunner, 2015; Kenney, 2016). This is also apparent in research which identifies that personality traits, particularly those associated with compassion, are subject to change across the life span (Srivista *et al.*, 2003; Roberts, Walton and Viechtbauer, 2006; Roberts and Mroczek, 2008).

Educational strategies to address this can support the nurse to internalise the construct (Berger and Luckman, 1966) of compassion as an integral part of their philosophy of nursing. This can influence characteristic adaptation of human personality (Coleman, 1988; McCrae *et al.*, 2000; McAdams and Pals, 2006; McCrae, 2011) and promote a collective approach to implementing compassion in the care context (Wear and Zarconi, 2008). My research findings advance this argument from the individual perspective, asserting that formal education for compassion in the nursing arena is vital to build upon baseline character, thus nurturing competence for compassion.

Individuals highlighted that developing competence for compassion went beyond the realms of formal educational strategies, identifying that it was also required in the context of the care environment. Role modelling was deemed to be a prominent strategy to influence compassion, evidenced by individual perceptions that experienced nurses were positioned in a role to “*champion*” best practice, therefore creating a context within which compassion could flourish. Social learning theory (Bandura, 1977) provides some insight into role modelling, identifying that learning occurs in the social world as a result of exposure to experiences and behaviours which others attend, retain and reproduce. Whilst commentators acknowledge that experiences in the practice context are a significant source of education (Du Toit, 1995; MacKintosh, 2006) to influence development of the generic values associated with professional identity (Gregg and Magilvy, 2001; Griffiths *et al.*, 2012), previous research has not fully elicited the influence of this specifically in terms of compassion. The work of Kneafsey *et al.* (2016) touches upon the potential of role modelling to influence compassion, but presents a collective insight of the research findings which blends the perceptions of nurses and individuals into one single representation. As a result, it is unclear if individuals themselves identified role modelling to be of importance and in fact, the published article suggests that this perception arose primarily from the professional point of view. My findings elucidate this point, strengthening the evidence to support the claim that individuals who have experienced nursing care, perceived role modelling in the context of the care environment to be an essential aspect of cultivating competence for compassion.

Individuals in my study identified that novice nurses were particularly vulnerable to imitating the negative behaviours they may be exposed to, due to their limited level of competence and insight into the nursing role. Imitation of negative behaviours was perceived to be influenced by the potential to conform to the norms of practice, with novice nurses having compassion “*knocked out of them*”, as they sought to blend in and acquiesce to the culture of the care context. However, this presents an overly simplistic view and fails to consider the nurse’s ability to overcome such challenges. Social cognitive theory (Bandura, 1986) advances the original tenets of social learning theory (Bandura, 1977) to offer a more comprehensive understanding of human learning, providing enhanced insight into how nurses may learn within the care context.

Social cognitive theory (Bandura, 1977) proffers that behaviour does not solely arise from observation, rather individual motivation and cognition also have a significant role to play. Social cognitive theory is based on the premise that behaviour develops as a result of both personal and environmental factors, which act together to determine outcomes. The social aspect of the theory acknowledges that human action is influenced by experiences observed in the social world, whilst the cognitive aspect acknowledges that human action is influenced by individual factors, which are instrumental in affecting motivation and the actions that ensue. This clearly links to aspects associated with intrinsic character for compassion, and also highlights the utility of educational strategies to build upon this further to nurture competence for compassion. The importance of the duality of this approach clearly emerged from my findings, through individual perceptions that biological and sociological factors,

together, contributed to enhancing psychological factors of human personality which could foster compassion in the context of nursing.

6.4.3 Motivation for Compassion

The findings identified that motivation for compassion was a central aspect of what individuals perceived compassion to involve. Motivation was thought to arise primarily from an intrinsic desire to care for others, which individuals recognised as a catalyst with potential to invoke compassion. Individuals perceived that nurses were led to a nursing career due to the fact they were fundamentally a caring and compassionate person, as a result of innate biological factors that positioned nurses with a metaphorical “*stamp on...[their] head*”. Congruence of career choice is vital to position people in an occupational role which fits their unique personality traits (Holland, 1959; Chamorro-Premuzic, 2015) and value based recruitment (VBR) strategies in nursing claim to enable this (HEE, 2014 a). However, my findings identified that individuals perceived some nurses to be incompatible with their chosen career, as they failed to demonstrate the ability to be compassionate. As a result, such nurses were deemed to have pursued an inappropriate career pathway.

Although commentators report that many nurses do demonstrate characteristic personality congruence with the role and are drawn to nursing careers as a result of an intrinsic motivation to care for others (Ditommaso *et al.*, 2003; Maben, Latter and Clark, 2007; Baughan and Smith, 2008; Newton *et al.*, 2009; Eley, Eley and Rogers-Clark, 2010; Baldacchino and Galea, 2012 a, b; Penprase *et al.*, 2013; Wood, 2014), increasingly it is becoming apparent that other factors also influence career choice. Factors related to perceived gender constructs, job security, job role, aptitude and social status can influence occupational selection (Johnson, Haigh and Yates-

Bolton, 2007; Miers, Rickaby and Pollard, 2007; Cho, Jung and Jang, 2010; Neilson and Jones, 2012), and thus, may also compromise decisions (Gottfredson, 2005) to embark upon a nursing career. My research findings highlighted that some nurses may have made compromised decisions to enter nursing, with individuals perceiving that such decisions had perhaps been motivated solely by financial reward.

Individuals found it objectionable to contemplate financial reasons as a motivating factor to embark on a nursing career, suggesting that this factor alone was an inadequate reason to be positioned in a nursing career. This suggested that individuals had internalised an affinity with traditional views of nursing as a vocation, reflecting the influence of history in relation to contemporary understanding of what was expected of nurses (Berger and Luckman, 1966; Burr, 1996; Gergen, 1999).

VBR strategies aim to identify nurses with the most appropriate values and attributes, however it is acknowledged that there is limited evidence to support the utility of some of the approaches currently being implemented (HEE, 2014 b).

Despite this challenge, my findings supported the efficacy of eliciting career congruence in nurses, as an essential aspect of striving to ensure that they possessed inherent competence and motivation for compassion. Although the notion of career congruence is apparent across more general discursive literature (Nauta, 2010) and implied in mandated VBR strategies (HEE, 2014 a), the existing empirical research into perceptions of compassion fails to acknowledge the relevance of this. My findings provide a novel perspective on career congruence in relation to motivation for compassion in the nursing context, advancing support for the philosophical

principles of VBR and raising implications for the recruitment and selection of nurses.

Across the findings it was apparent that motivation for compassion also stemmed from what individuals framed as positivity, exemplified in claims that in the absence of positivity “*you’ve got nothing*”. Positivity has clear links to human personality (McCrae and Costa, 1987, 1997; Schultz and Schultz, 2005) and is regarded as key to invoking human responses which motivate individuals to engage in pro social behaviours such as action for compassion (Hefferon and Boniwell, 2011). My findings elicited various examples of nurses failing to demonstrate a positive approach, which subsequently ensued in a failure to demonstrate compassion. In such circumstances, individuals highlighted that nurses seemed to be simply “*going through the motions*” and, although clinical care may have been perceived to be of high quality, the “*human touch*” was missing. This missing element ensued in individuals perceiving they were objectified, rather than individualised, highlighting that motivation was an essential aspect of compassion to avoid such negative perceptions. Although the idea that ‘becoming motivated’ is elicited in the work of Kneafsey *et al.* (2016), this stems primarily from professional perspectives. My research builds upon this idea further, exclusively representing individual perceptions, and providing further insight into the need for nurses to exhibit a character that demonstrates both competence and motivation for compassion.

Building further on the concept of motivation for compassion, individuals identified that nurses required particular socio-contextual conditions to sustain this. A primary

condition was dependent on an organisational culture for compassion (NHS Leadership Academy, 2013; Boddoo-Jones and Swailes, 2015), whereby effective leadership was regarded as instrumental in setting standards for compassion. Nurse leaders are central to cultivating an environment within which compassion can flourish (Briner and Pritchard, 1997; Gardner *et al.*, 2005; Brown, 2013; NHS Leadership Academy, 2013; NHS England, 2016), inspiring and motivating nurses to implement a collective vision for best practice across the organisation (Putnam, 1993; Leana and Van Buren, 1999). Leaders are thought to be a prominent source of role modelling for compassionate attributes (Mathews and Gupta, 2015; Eldor and Shoshani, 2016), and this notion was apparent in my findings through perceptions that nurses required leaders to be visible in the care context, leading by example to promote motivation for compassion in others.

Individuals suggested that reciprocal interactions between nurses and nurse leaders and nurses and individuals experiencing care, were essential for compassion to flourish. This was apparent in claims that if nurses were not treated with compassion themselves, it was questionable if they could be motivated to treat others with compassion. Individuals assumed that nurses required reciprocal appreciation from both nurse leaders and the individuals for whom they were caring, apparent in claims that nurses “*can’t pour all [their] compassion endlessly down a well*”. When nurses experienced negative reciprocity, individuals perceived that there was potential for similar responses and although not explicitly stated, the findings suggested that motivation for compassion could wane. Individuals identified that negative reciprocity could be a catalyst to influence nurses to similarly respond (Regan, 1971;

Cialdini 2006), through the notion that “*behaviour breeds behaviour*”. Despite the potential for reciprocated responses, individuals asserted that nurses needed to rise above such negative interactions to ensure that compassion was an integral aspect of their practice. Across the evidence base to currently inform compassion in the context of nursing, the notion of reciprocity is a unique concept that has arisen exclusively from my findings. Although other commentators suggest that reciprocity is essential to motivate people to perpetuate social norms (Regan, 1971; Bandura, 1977; Cialdini, 2006; Vallant and Neville, 2006), this has not emerged from previous empirical research to explore perceptions of compassion. My findings provide a unique insight into the fact that reciprocity is essential between all agents in the care context, as a means to foster a collective approach (Hedge and Yousif, 1992; Ritzer, 2004) which reinforces the importance of compassion (Dawkins, 1976; Herbst, Swengros and Kinney, 2010; Dimitriadou, Pizirtzidou, and Lavdaniti, 2013) and thus, promotes motivation for compassion.

6.4.4 Connecting for Compassion

The importance of developing effective relationships with the individual experiencing care, was clearly evident in the findings as an essential aspect of what compassion involved. Relationships were identified as integral to the professional attributes and interactions for compassion presented earlier (Figure 13). The individual’s initial impressions of the nurse were often fundamental to establishing the ensuing professional relationship, with negative impressions more likely to have a negative impact on the relationship that transpired. This was apparent in examples of initial interactions where nurses failed to connect at a human level, as a result of a lack of preliminary introductions or a failure to make eye contact. This could

negatively affect the relationship, and was exemplified in experiences whereby the individual simply “*shut... down*”.

Although the significance of initial impressions has not been elicited from previous research, the importance of establishing relationships has been clearly acknowledged. Commentators have identified this through research to explore professional perceptions (Perry, 2009 a; Lown, Rosen and Martilla, 2011) and collective perceptions of compassion (Sanghavi, 2006; Van der Cingel, 2011; Dewar, Pullin and Tocheris, 2011; Kneafsey *et al.*, 2016), although this has been less frequently identified through the perceptions of individuals who have experienced care. In the palliative care context, Sinclair *et al.* (2016 a) highlighted that individuals identified relationships to be an essential aspect of compassion. However, it could be argued that such relationships are an expected interaction with individuals who are at the end of life, and who may be experiencing an elevated level of suffering (Nouewen, McNeill and Morrison, 1982; Young-Mason, 1988; Nussbaum, 1996; Schantz, 2007). Although this undoubtedly offers a robust contribution to the knowledge base, my findings advance this further by presenting the argument from the perspectives of individuals in a more generic nursing context.

My findings provided additional insight into the importance of establishing relationships that were founded on making connections with individuals in all contexts where they may experience nursing care, regardless of the level of suffering or vulnerability that nurses perceived they may be experiencing (Tudor, 2001; Van der Cingel, 2009; Dewar, Pullin and Tocheris, 2011). Clearly relationships are a

fundamental aspect of nursing (Tresolini and The Pew Fetzter Task Force, 1994; Nolan *et al.*, 2004) particularly in terms of fostering compassionate approaches to care (Dewar and Nolan, 2013), but it is evident that eliciting this as an integral aspect of individual perceptions of compassion requires further empirical support. My research findings strengthen this argument, highlighting that individuals themselves perceived relationships to be an essential foundation from which to cultivate the nurse's ability to connect with the individual at a human level and thus, facilitate a more positive experience of compassion.

As already discussed, making a human connection with the individual was regarded as vital to establish effective professional relationships. However, the findings identified that some nurses were unable to achieve this, failing to demonstrate the ability of "*tuning in to people*". Variances in affective style are known to exist as a result of differences arising from unique human personality, affecting a person's ability to connect with others on an emotional level (Davidson, 2003; McCrae and Costa, 2008; Baron-Cohen, 2012). Acknowledging that differences in human personality exist highlights the importance of ensuring that, in the first instance, nurses possess fundamental character, competence and motivation to support them to connect for compassion. The ability of the nurse to connect with the individual at an emotional level is considered to be a vital mechanism to invoke action for compassion (Nouwen, McNeill and Morrison, 1982; Lown, Rosen and Martilla, 2011; Dewar, Pullin and Tocheris, 2011), and a factor that is identified as important by individuals themselves in the empirical research of Sinclair *et al.* (2016 a). Establishing human emotional connections can undoubtedly influence the

development of relationships (Todres, Galvin and Dahlberg, 2007; Todres, Galvin and Holloway, 2009; Galvin and Todres, 2013; Coscrato and Bueno, 2015), a notion identified in my findings which highlighted that “*getting into somebody’s psyche*” was of vital importance to compassion.

Individuals identified that socio-contextual conditions, specifically relating to human resources and contemporary systems and processes, could influence compassion. In care contexts with lower staffing levels and higher workloads, individuals claimed that time for compassion seemed to be limited. Other commentators have reported that lower staffing levels can ensue in less favourable nursing outcomes (Aiken *et al.*, 2002; Needleman *et al.*, 2002; Lang *et al.*, 2004; Rafferty *et al.*, 2007; Cho and Yun, 2009; West *et al.*, 2009; Duffield *et al.*, 2011; Aiken *et al.*, 2014; West *et al.*, 2014) and identified that nurses often spend minimal amounts of their working day in direct contact with the individuals for whom they are caring (Westbrook *et al.*, 2011; RCN, 2013; Spinks, 2013; Ball *et al.*, 2014). However, although this research identifies challenges to the clinical aspects of nursing, it does not specifically identify that compassion is an aspect of nursing practice that may be affected. My findings strengthen this point, highlighting that individuals in my study perceived that lower staffing levels and higher workloads could inhibit compassion.

The findings identified that limited time resulted in a decreased capacity for the nurse to connect with the individual for whom they were caring. In these circumstances, individuals asserted that this detracted the nurse’s attention away from the person, in favour of investment in technical activities (Lomas and West, 2009; Stokowski,

2013; Wright and McSherry, 2013; Ansell, Meyer and Thompson, 2015; Boston and Brice, 2015), a claim also identified by nurses themselves in previous research (Cho and Yun, 2009; Duffield *et al.*, 2011; RCN, 2011; RCN, 2012 a; Lupton and Croft-White, 2013; Unison, 2013). Individuals perceived that this had the potential to occur even in circumstances where nurses may have aspired to demonstrate character, competence and motivation for compassion as their focus was on “*getting the job done*”; an issue also identified through the research of Ball *et al.* (2012). This decreased capacity to make connections was identified in individual experiences which reflected a sense of being “*herded*” through the system due to diminished nurse ratios. As a result, nurses were more focused on completing tasks and “*doing things to*” the individual, rather than being “*with*” the individual. This led to feelings of being dehumanised as the nursing care approaches that were implemented objectified the individual, merely treating them as a task to complete rather than connecting with them at a human level.

Commentators acknowledge that the social contexts within which people function can exert influence on their succeeding actions (Giddens, 1986; Horsburgh and Ross, 2013). This is evident in the theoretical tenets of symbolic interactionism, which asserts that experiences of social processes influence people to become a product of the social world around them (Mead, 1934; Blumer, 1969; Lalljee, 1996), as they become entrenched in the contextual influences of presenting situations that they encounter. Consequently, nurses can also become entrenched within the contextual influences of the care context, perhaps losing sight of the individual as they focus on technical activities, which are often prioritised when it is perceived that time and

resources are limited. However, there is evidence to suggest that time constraints should not be accepted as an inhibitor of compassion, with claims that compassion requires only minimal expenditure of time and effort through the implementation of small acts of kindness (Fogarty *et al.*, 1999; Perry, 2009 a; Lewis, 2012; Reimer, 2013; Bramley and Matiti, 2014; Reimer, 2015; Scammell, 2015). This is evident in my study, through examples of nurses exhibiting what individuals perceived to be an enhanced disposition for compassion, through ‘momentary vignettes’ for compassion. This suggests that due consideration needs to be taken to promote strategies that support and encourage all nurses to implement such an approach.

Moreover, individuals identified that there was a potential for nurses to fail to notice distress or vulnerability when focused on technical activities, thus failing to initiate opportunities to implement action for compassion. Commentators highlight that ‘inattentional blindness’ (Mack and Rock, 2000; Paley, 2014) can influence personal arousal to recognise the needs of others (Dovidio *et al.*, 1991) when attention is invested in other activities (Darley and Batson, 1973; Simons and Chabris, 1999; Paley 2014). In particular, cognitive resources can become pressured and the ability to recognise the needs of others is affected by physiological factors which can predispose the implementation of merely adequate responses (Zak, 2011). Although other research acknowledges that low staffing levels can influence the nurse’s capacity to fulfil all aspects of the caring role (Westbrook *et al.*, 2011; RCN, 2013; Spinks, 2013; Ball *et al.*, 2014), due to time being invested in other activities (Patterson, Ebright and Saleem, 2011), this evidence does not solely focus on compassion. The focus of this previous work primarily identifies the concept of

‘care left undone’ (RCN, 2011), often in relation to providing comfort or engaging with people (Ball *et al.*, 2013), implying that making human connections for compassion may be impacted by lower staffing levels. However, the impact on compassion as an aspect of ‘care left undone’ is not fully elucidated.

My findings clearly uncover the issue of ‘care left undone’ in relation to compassion, highlighting that individuals regarded lower staffing levels to be a catalyst to negatively impact on the nurse’s capacity to connect with the individual and demonstrate action for compassion. However, some nurses were identified as having the ability to overcome this, due to an enhanced dispositional character for compassion. As previously discussed, although determining the reasons for this ability were beyond the scope of my study, self-regulation, self-agency, self-efficacy or compassion resilience were suggested as plausible explanations. This suggests that although a baseline character for compassion may be a pre requisite, approaches to cultivate competence for compassion through the development of personal strategies to sustain motivation for compassion in the complexity of contemporary nursing practice, are required.

In contrast, in care contexts with higher human resource ratios, my findings highlighted that humanising approaches to nursing care were more effectively enabled, contributing to the nurse’s ability to make connections and thus promote more positive perceptions of compassion. Specifically, in care contexts where one-to-one care was more prevalent, individuals highlighted that nurses seemed to have more time to spend with the individuals for whom they were caring, which other

commentators suggest ensues in more favourable clinical outcomes (Kalisch, 2005; Kingma 2009; Kalisch, Landstrom and Williams, 2009; Kalisch, Tschannen and Lee, 2011; Ball *et al.*, 2013). Individuals in my study highlighted that having more time enabled nurses to notice distress or vulnerability and respond with a humanising approach, consequently facilitating appropriate connections and action for compassion. In these contexts, despite the challenges of contemporary nursing systems and processes, the ability of the nurse to connect was not affected. This was exemplified in the Intensive Critical Care Unit and community setting, where staffing levels seemed to be more effectively matched to care dependency requirements. This suggested that adequate staffing levels were a vital mechanism to foster compassion and achieve more favourable outcomes, a notion identified by other commentators (RCN, 2010 b; Hewison and Sawbridge, 2016).

6.4.5 Action for Compassion

Action for compassion was identified as the final of the five elements underpinning what individuals perceived compassion to involve. It was evident that equilibrium of the four preceding elements discussed so far was essential in order to facilitate action for compassion and thus, foster humanising approaches to nursing care. When there was disequilibrium of the elements, action for compassion could fail to ensue and dehumanising approaches to nursing care had the potential to emerge. Therefore, character, competence, motivation and connecting for compassion were vital, and equilibrium of each element was of paramount importance.

Action for compassion was primarily dependent on the personal attributes, professional attributes and the ensuing interactions that nurses engaged in with the individuals for whom they were caring. Individuals identified that character and

associated personal attributes were an antecedent for compassion, translated into actions such as nurses taking the time to listen, offer reassurance or show kindness. Other commentators have suggested that personal attributes are a precursor for compassion (Day, 2015) and highlighted that the ‘virtues’ of the nurse act as an antecedent of ‘virtuous response’ (Sinclair *et al.*, 2016, p197). However, my findings advance this claim from the individual perspective, providing an extensive range of personal attributes (Figure 12) from which compassion can evolve. In addition, my findings identified a wide range of professional attributes and interactions (Figure 13) that individuals deemed to be indicative of compassion, some of which are reflected in other studies. This included knowing the person (Dewar and Mackay, 2010; Bramley and Matiti 2014; Sinclair *et al.*, 2016), individualising the person (Cornwell and Goodrich 2009; Perry, 2009 a; Lown, Rosen and Martilla, 2011), assuming a partnership approach to care (Burhans and Alligood, 2010), negotiating caring interventions (Sanghavi, 2006) and providing information to facilitate choice and control (Kret, 2011). Individuals felt that having knowledge of the person was also a vital catalyst to promote connections and develop relationships, as nurses became “*a part of their world*”, implementing actions for compassion that were individualised, rather than homogenised (Binfa *et al.*, 2013).

The findings identified that equality was an essential aspect of action for compassion, facilitating professional attributes and interactions and apparent in claims that individuals desired to be positioned at an equivalent level with the nurse who was caring for them. The notion of equality is regarded as an important aspect of nursing practice, promoting a power balance to foster empowerment

(Kangasniemi, 2010) through partnership approaches to care (Henderson, 2003).

However, fostering equality to shift the balance of power from the nurse to the individual experiencing care has not previously been suggested to be of importance to compassion specifically. Person centred (McCormack and McCance, 2006, 2010) and relationship focused (Tresolini and The Pew Fetzter Task Force, 1994; Nolan *et al.*, 2004; Dewar and Nolan, 2013) approaches are known to be important to compassionate nursing practice, and evident in policy drivers which mandate approaches to promote the philosophy of ‘nothing about me without me’ (DH 2010, c, p13). Although this implies that equality in the professional relationship is required to achieve this, previous empirical research to explore perceptions of compassion has not uncovered this. This finding presents further new insight into compassion, emphasising the need for nurses to position the individuals they are caring for at a level of equivalence. This requires professional boundaries to be blurred, identifying that compassion is not defined by what the nurse chooses to ‘do’ to the individual, rather it is what the nurse chooses to do together ‘with’ the individual (Von Dietze and Orb, 2000).

Equilibrium of character, competence, motivation and connecting for compassion lead to action for compassion, which is fundamentally exemplified by humanising approaches to care. Humanising for compassion is the core and central embodiment of what individuals perceived compassion to involve. Humanising approaches to care involved treating the individual as a thinking, feeling human being and actively including them in the caring relationship. The notion of treating the individual as human to facilitate compassion is also evident in the Charter for Compassion

(Armstrong, 2011), which provides a conceptually driven framework to support the implementation of compassionate behaviours across wider society. Although humanising approaches to nursing care in general have been suggested in other conceptually driven literature (Todres, Galvin and Dahlberg, 2007; Todres, Galvin and Holloway, 2009; Galvin and Todres, 2013), this notion has only recently arisen in relation to compassion through a discursive commentary arising from the medical domain. Gaufberg, and Hodges (2016) purport that humanising practices are founded on intrapersonal, interpersonal, systemic and social factors. This suggests that compassion can be influenced by factors associated with character, the ability to connect and establish relationships, experiences in the social world and the care context itself. However, the commentary merely provides a professional opinion to support this claim, failing to support the argument from an empirical perspective. The notion of humanising for compassion is a unique aspect that has not been elicited from empirical research to date to explore perceptions of compassion. My findings therefore provide an original contribution to the current empirical evidence base that informs compassion, identifying that humanising approaches to nursing care are vital to compassion.

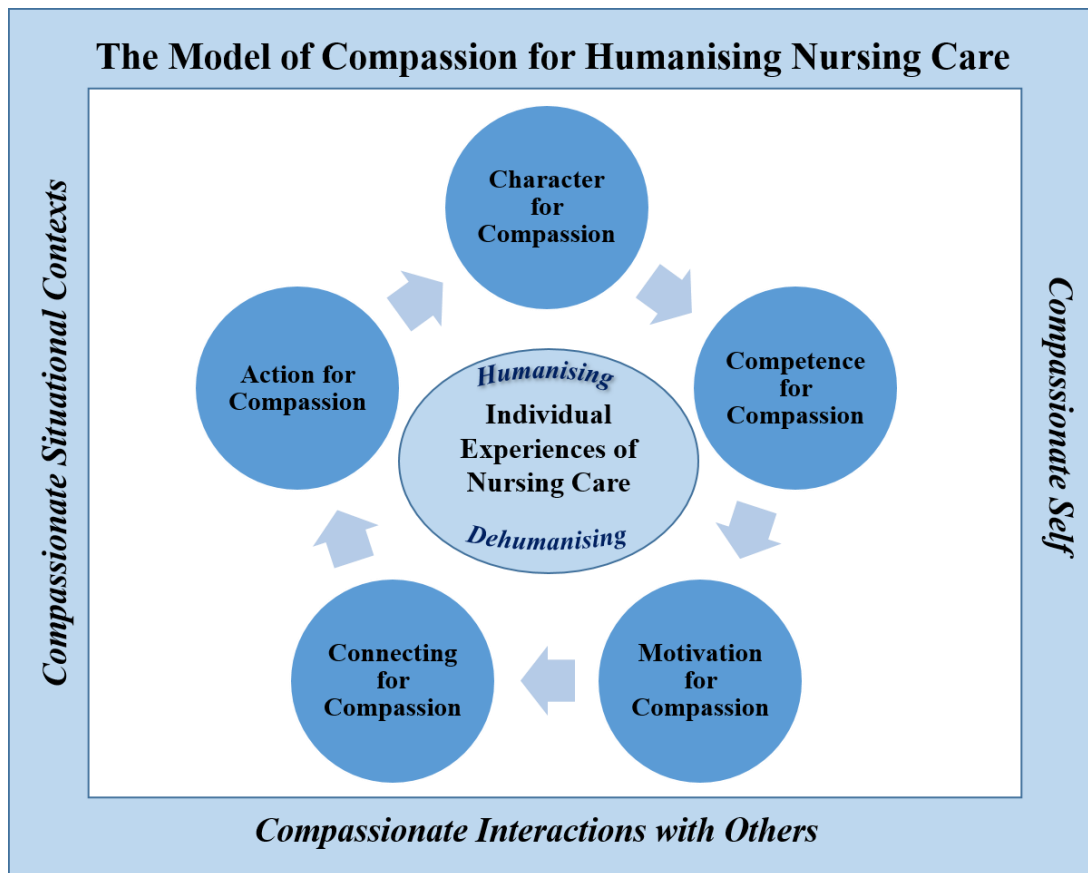
Individuals reported that they desired, indeed required, to be treated as human beings. They perceived that compassion was exemplified by attributes such as kindness, and interactions which promoted their involvement in the care experience. In these circumstances, it was evident that nursing care was founded on the development of positive professional relationships to connect with, and individualise the person, thus facilitating a humanising approach to care. In the absence of such an

approach, individuals felt dehumanised as they perceived they were objectified by nurses who treated them merely as a task to be completed. These findings therefore provide an innovative way of understanding compassion, fundamentally eliciting that in my study, compassion was embodied by nursing care approaches which humanised the individual. This is the core and central aspect of compassion that has been derived from my research, and a concept which contributes to the originality of this thesis. As previously discussed, the five elements of compassion discussed so far provided a foundation from which to construct the grounded theory, this is presented in the following section of the chapter in the form of a model for compassion.

6.5 The Model of Compassion for Humanising Nursing Care

As discussed earlier, as a result of in depth analysis and advanced conceptualisation of the findings, a propositional grounded theory was constructed to represent the complex nature of what individuals perceived compassion to involve. This is presented as *The Model of Compassion for Humanising Nursing Care* (Figure 18), and incorporates the five elements of compassion discussed above, and the principal dimensions of compassion briefly introduced in Chapter 5. The commentary that follows explicates the propositional theoretical assertions of the model that have been derived from, and are grounded in, the data that was collected throughout this research to explore individual perceptions of compassion in nursing.

Figure 18: The Model of Compassion for Humanising Nursing Care



The Model of Compassion for Humanising Nursing Care provides a comprehensive grounded theory to represent individual perceptions of compassion within the context of nursing. It is founded on a biopsychosocial perspective to acknowledge the influence of biological, psychological and socio-contextual factors. The biopsychosocial perspective historically originates from the premise that human health and disease is subject to influence by an integrated range of factors (Engel, 1989), offering a more holistic understanding of humans which has been increasingly applied to the psychology focused research arena (Gilbert, 2002). However, the application of a biopsychosocial perspective to understanding compassion in the context of nursing provides a unique approach, therefore establishing the basis for the originality of the grounded theory that is presented in this thesis.

The individual lies at the heart of *The Model of Compassion for Humanising Nursing Care*, which proposes that perceptions of compassion are fundamentally characterised by experiences of humanising or dehumanising approaches to nursing care. The model identifies that compassion is dependent on a series of five elements. As discussed previously, these five elements comprise *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. Equilibrium of these five elements of compassion can enable humanising approaches to nursing care, whilst disequilibrium can enable dehumanising approaches to nursing care. When an individual experiences nursing care which engenders equilibrium (a state of balance) of the five elements of compassion, it is more likely that they will perceive humanising approaches to care. Conversely, when an individual experiences nursing care which engenders disequilibrium (a state of imbalance) of the five elements of compassion, it is more likely that they will perceive dehumanising approaches to care. Engendering equilibrium to promote individual experiences of humanising approaches to nursing care, is the principal foundation of what compassion embodies in the context of nursing.

The Model of Compassion for Humanising Nursing Care identifies that three overarching principal dimensions of compassion can influence equilibrium of the five elements of compassion and these relate to *Compassionate Self*, *Compassionate Interactions with Others* and *Compassionate Situational Contexts*. *Compassionate Self* relates to self-propensity and character for compassion, and is exhibited in attributes and interactions which primarily arise from the intrinsic biological and

psychological factors that are known to be associated with human personality. These attributes equip the nurse with a fundamental level of competence and motivation for compassion, which supports their ability to establish human connections and develop relationships with the individuals for whom they are caring. In turn, this can support the nurse to implement action for compassion, by adopting approaches to care which humanise the individual. When the nurse fails to demonstrate fundamental character, competence and motivation for compassion, dehumanising approaches can emerge through a failure to connect and implement action for compassion. Therefore, a baseline ‘potential’ for *Compassionate Self* is a pre requisite foundation from which compassion can be nurtured and cultivated further. To facilitate cultivation of compassion, exposure to *Compassionate Interactions with Others* is required.

Compassionate Interactions with Others involves socio-contextual experiences to learn about compassion through education in the home, school, formal nurse education context and the nursing practice environment. These learning experiences can build upon intrinsic biological factors, shaping psychological aspects of human personality to enhance fundamental character, competence and motivation for compassion. This may involve the promotion of personal strategies to support nurses to sustain compassion through aspects which relate to an enhanced disposition for compassion, such as those associated with self-regulation, self-agency, self-efficacy and compassion resilience. Reciprocal interactions between nurses and nurse leaders and nurses and individuals experiencing care are also important, in terms of exerting influence on the nurse’s motivation to implement action for compassion.

Compassionate Interactions with Others can cultivate collective values and

approaches to perpetuate compassion, thus creating a culture within which compassion can flourish. In order for nurses to sustain compassion, they also need to be exposed to *Compassionate Situational Contexts*.

Compassionate Situational Contexts include socio-contextual care environments that are supported by adequate staffing levels and skill mix ratios. Addressing these factors can enable the nurse to fulfil all aspects of the role with compassion, as they function within contemporary nursing care systems and processes to manage supportive technical care and fundamental care activities simultaneously. Adequate human resource ratios can support nurses to address both the art and science of nursing with equal parity, enabling them to recognise the needs of others and connect at a human level to create opportunities for compassion. An organisational culture for compassion is required, with nurses themselves experiencing compassion through the influences of nurse leaders and those at the very top of caring organisations. Such compassionate organisational cultures can support the nurse to sustain character, competence and motivation for compassion and in turn, motivate them to implement action for compassion by adopting humanising approaches to nursing care.

Compassion in nursing can, therefore, be more fully understood through a biopsychosocial lens. This ideology is exemplified in *The Model of Compassion for Humanising Nursing Care*, which provides insight into the complexity of what compassion in nursing involves and highlights the complementary influences that are exerted by forces of nature and nurture. *Compassionate Self, Compassionate*

Interactions with Others and *Compassionate Situational Contexts* are principal dimensions that are required to support nurses to implement the elements of what compassion is perceived to involve. The findings from my research identifies that equilibrium of these three principal dimensions of compassion can enable equilibrium of the five elements of compassion, and thus facilitate humanising approaches to care. Disequilibrium of these principal dimensions of compassion can enable disequilibrium of the elements of compassion, and thus facilitate dehumanising approaches to care. Experiencing humanising approaches to nursing care was of fundamental importance to the individuals in my study, and identified as the primary foundation from which positive perceptions of compassion in nursing can emerge.

The discussion that has been presented throughout this chapter to explore the findings in more depth and present *The Model of Compassion for Humanising Nursing Care*, has elicited links with existing knowledge and clarified new insights which demonstrate an original contribution to knowledge. In addition, the discussion has also elicited accordance with the key theoretical tenets of symbolic interactionism and social constructionism, presented in Chapter 3. Symbolic interactionism purports that humans develop a unique interpretation of the social world, as a direct result of the dynamic interactions they have experienced with others within specific contextual environments (Blumer, 1969; Handberg *et al.*, 2015). Social constructionism purports that humans create and sustain knowledge through the social practices in which they engage. This is founded on the externalisation, objectification and internalisation of phenomena, which is influenced

by factors arising from history, personal experiences and the prevailing culture (Berger and Luckman, 1966; Burr, 1996; Gergen, 1999).

It is evident that the individuals in my study constructed their perceptions of compassion as a result of unique personal experiences of care, encountered through interactions with nurses in a diverse range of care contexts. In addition, individuals also constructed their perceptions of compassion through other life experiences encountered in the social world, such as previous employment or exposure to compassion in the early years. As a result of these experiences, individuals internalised a personal reality of what they perceived compassion to involve, attaching significance to particular attributes and interactions which they deemed to represent it. Furthermore, individuals perceived that nurses also constructed their perceptions of compassion through similar experiences in the social world, influenced by aspects of self, interactions with others and the situational contexts within which these occurred. As a result, this identified that compassion was influenced both at a micro and macro level by biological, psychological and socio-contextual factors, thus highlighting that compassion can only be more fully understood through a biopsychosocial lens. These factors have contributed to the construction of *The Model of Compassion for Humanising Nursing Care*, which presents an innovative and original insight into compassion and provides a framework from which compassion can be cultivated within the nursing care context.

6.6 Recommendations

As a result of the implications that have arisen throughout the preceding discussion of this chapter, a series of recommendations are proposed. These recommendations consider strategies for practice, policy, education and research, providing a way forward that could enhance compassion in the context of nursing.

6.6.1 Recommendations for Practice

The recruitment and selection of candidates who exhibit a fundamental level of affinity with *Compassionate Self* is required, in order to provide a baseline foundation from which compassion can ensue within the nursing care context. A variety of approaches could be considered to support the appropriate selection of candidates who demonstrate the ‘potential’ for compassion, using strategies to identify affinity with the extensive range of personal attributes (Figure 12) that were identified from my study. This approach would support selection of the most appropriate candidates who exhibit the ‘potential’ to implement the elements of compassion which relate to character, competence, motivation, connecting and action for compassion. Approaches to selection could draw upon techniques that use authentic case study examples of individual experiences of care to assess the candidate’s ‘potential’ for *Compassionate Self*, seeking to elicit the attributional qualities which fundamentally epitomise compassion. This would acknowledge the importance of recognising the needs of the individual, thus placing the person as the primary focus of care in contemporary nursing care practice.

Whichever approach to recruitment and selection is taken, the focus must be on identifying the candidate’s ‘potential’ for compassion, which would offer a foundation of character, competence and motivation that could be nurtured and

cultivated through appropriate educational strategies. This would acknowledge that whilst some candidates may be drawn to a nursing career solely due to an intrinsic desire to care for others, others may be drawn to a nursing career in response to additional factors. Such approaches would be commensurate with the acceptance that although candidates may not be the finished product at the point of selection, they demonstrated affinity with, and aptitude for, the elements that are integral to the level of *Compassionate Self* that is required of the professional nurse.

An organisational culture for compassion is required, with nurse leaders and those at the top of caring organisations exhibiting *Compassionate Self* themselves, to disseminate a vision for compassion through *Compassionate Interactions with Others*. Leadership strategies need to evolve from a transformative perspective, supporting and inspiring others to implement a vision for compassion in nursing. Ongoing support for nurses is required via approaches which identify barriers to compassion, implement resolutions to overcome these and encourage sustained development of compassion in nurses. Nurse leaders need to lead by example themselves, through a vision for compassion that they share with the wider team and inspire others to replicate, providing nurses with the opportunity to function within *Compassionate Situational Contexts*. To achieve this, nurse leaders need to be equipped with the skills required for the prominent role modelling position that they assume, thus promoting care contexts within which compassion can flourish. In turn, *Compassionate Situational Contexts* will be created, within which character, competence and motivation for *Compassionate Self* can enable nurses to implement action for compassion.

The contemporary systems and processes within which nurses operate, require consideration in order to create *Compassionate Situational Contexts*. In an advancing technological age, nurses need to be supported to balance both fundamental and technical skills to ensure that they are able to sustain their capacity and motivation for compassion. New ways of working need to be implemented, which embrace technology as a means to add value to nursing care, rather than diminish it. This requires the implementation of innovative systems and processes to create *Compassionate Situational Contexts*. Promoting the implementation of ‘momentary vignettes’ for compassion needs to be acknowledged as a means to support this, particularly within the challenging contemporary care context where nurses are expected to manage multiple care interventions simultaneously.

A review of staffing levels is imperative. It is evident that having adequate staffing levels in all care contexts, particularly in relation to Registered Nurse ratios, is vital to support the nurse to sustain character, competence and motivation for *Compassionate Self*. Adequate human resources are pivotal to ensuring that nurses are not overwhelmed by clinical and technical workload, which can result in missed opportunities to connect with the individual at a human level, and a failure to implement action for compassion. A review of staffing levels may incur financial impacts to caring organisations, but arguably, this financial cost is insignificant given the human impact that experiencing a lack of compassion can have on the individual. Appropriate skill mixes and staffing levels can offer *Compassionate Situational Contexts* that provide adequate time and opportunity to sustain *Compassionate Self*, motivating nurses to connect with the individuals they are

caring for and implement action for compassion through humanising approaches to nursing care.

6.6.2 Recommendations for Policy

Although not directly related to the nursing context, it is evident that early years education for compassion is necessary to develop fundamental levels of *Compassionate Self* in members of society, particularly those who may elect to pursue a nursing career. It is therefore important that social policy is developed to create a prevailing societal culture that fosters compassion as an inherent collective value, equipping young people with the ability to be compassionate in the adult years. To support collective compassionate values to flourish in contemporary society, primarily there is a need to consider the development of *Compassionate Self* through *Compassionate Interactions with Others* in the home and school environment. Learning about compassion is the fundamental catalyst to embed compassion in society, supporting young people to develop a *Compassionate Self* through the social construction of knowledge and understanding of compassion in the early years. This approach can actively work towards developing socially collective ideals, aspirations and a fundamental character for *Compassionate Self* in potential nurses of the future. It can also foster reciprocity between agents, influencing future reciprocal interactions between nurses and individuals experiencing care and further cultivating action for compassion in the care context.

The role of individuals who have experienced care needs to be strengthened in terms of their contribution to future policy development related to nursing practice.

Although current policy exists which identifies the importance of public involvement in healthcare and issues related to nursing, it is evident that there has been a level of

tokenism involved in this. Individuals who have experienced care need to be specifically involved in policy development that focuses on relational issues of care. Individual insight has been invaluable to explicating the understanding of compassion that has been presented in this thesis, and this insight could be equally invaluable to additional aspects of nursing relating to experiences of care.

6.6.3 Recommendations for Education

Formal nurse education strategies to nurture competence for *Compassionate Self* need to be sustained in the pre and post registration period. In the nurse education arena, learning about compassion needs to be founded on understanding individual perspectives. This involves listening to, and engaging with, narratives and stories which explicate the individual experience of care. Learning from authentic experiences can provide a platform from which to develop nursing care approaches which enable the nurse to see things from the individual's perspective and recognise the person as a unique human being. Strategies to enhance self-regulation, self-agency, self-efficacy and compassion resilience need to be considered, embracing approaches which may support the nurse to sustain character, competence and motivation to connect with others and implement action for compassion.

Education needs to ensure that nurses acknowledge the importance of demonstrating a minimum standard for compassion in the nursing care context. This needs to focus on encouraging nurses to identify opportunities for 'momentary vignettes' for compassion, particularly in circumstances where the challenges and pressures of the contemporary nursing care context may be perceived as overwhelming. Nurse academics need to ensure that education continues to focus on fundamental core values and evidence based clinical and technical care with equal parity. This can

support nurses to maintain an appropriate balance between the art and science of nursing simultaneously. Education is the key catalyst to cultivate compassion in the nursing context via transformative *Compassionate Interactions with Others* which develop the nurse's *Compassionate Self*, particularly in terms of character, competence and motivation for compassion.

Education for compassion needs to be strengthened in the clinical care context, with appropriate role models assuming responsibility for the learning and development of less experienced staff. Support in the care context for novice nurses needs to be facilitated by more experienced nurses who have been selected for their ideals, aspirations and their personality congruence with *Compassionate Self*. Such individuals are most appropriately positioned to promote best practice, inspiring others to imitate and sustain action for compassion in the care context.

Compassionate Interactions with Others involves learning about compassion through exemplary role models in the care context and is evidently a powerful strategy to develop *Compassionate Self* in others.

6.6.4 Recommendations for Research

Further research needs to be conducted to investigate *The Model of Compassion for Humanising Nursing Care* with other individuals who have experienced nursing care, across other care contexts. In addition to investigating the model with other individuals, further research could also explore the model with Registered Nurses, student nurses, nurse leaders, nurse academics and other healthcare professionals to establish wider acceptance and resonance of the model across stakeholder groups. Although the model presents a propositional grounded theory to inform compassion, such additional empirical research could transform this unique and original grounded

theory into one that is universally accepted as a framework to facilitate compassion across a wide range of healthcare professional groups who function within a caring context.

Unexplained emerging issues that were beyond the scope of my study offer additional avenues for further investigative inquiry. In particular, the concept of enhanced disposition for compassion could be explored further with Registered Nurses who are identified as having exceptional levels of competence and motivation for compassion. This could create further insight into aspects of *Compassionate Self* and consequently enhance recruitment strategies to select the most appropriate people to assume a position in the nursing profession. Additionally, it could also provide further insight into appropriate strategies to promote and sustain the nurse's competence and motivation for compassion in the care context.

6.7 Limitations of the Research

In any research, despite the implementation of strategies to enhance rigour, inevitably some limitations will arise (Barbour, 2001; Kalof, Dan and Dietz, 2008). Acknowledging these potential limitations through a reflexive critique to consider key points, therefore provides further support to the trustworthiness of the research (Trafford and Leshem, 2008). The discussion that follows clarifies the potential limitations that have arisen from the research that has been presented in this thesis.

As discussed in the introductory chapter, the primary aim of the research question was to investigate individual perceptions of compassion through an exploration of personal experiences of nursing care with Registered Nurses in the professional nursing care context. However, throughout the research process it became apparent that individuals often drew on experiences with other health care professionals, or their own life experiences encountered in other contexts. This highlighted potential challenges to delineate if the care experiences they discussed through data collection had occurred with Registered Nurses, student nurses, support workers or doctors. Although this is a potential limitation impacting utility of the findings to professional nursing, it must be acknowledged that in all instances, individuals proceeded to translate these diverse experiences to their perceptions of compassion within the context of nursing. Translating experiences in this way supports the underpinning theoretical influences of this thesis, which claim that individuals construct their subjective perceptions of phenomena through social experiences encountered with others in a diverse range of contexts in the social world (Mead, 1934; Berger and Luckman, 1966; Blumer, 1969; Burr, 1996; Gergen, 1999). Rather than a limitation per se, this therefore suggests that perceptions of compassion are also constructed through diverse social experiences in the social world. It is these very experiences which individuals drew upon to construct what they perceived compassion to involve, subsequently applying this to the context of nursing.

A further potential limitation arises from the target sample population. As discussed in Chapter 4, the target sample was identified from an existing university ‘Service User and Carer’ group, the members of which were in an established role to share

narratives of their experiences with undergraduate health students. As a result of this experience, individuals were often highly articulate in their views, due to extensive reflection on the experiences they had encountered. It could be argued that this raises a limitation, particularly in terms of individuals having an ulterior motive to participate in the research. However, rather than a limitation, this enhanced ability to reflect on their experiences offered a strength to the research in terms of generating rich data, particularly given the complexity of exploring the nature of what compassion was perceived to involve.

At the point of data collection, some participants in the sample were discovered to be retired Registered Nurses, whilst others were involved as active members of NHS public involvement groups, Care Quality Committee inspection groups or local voluntary agencies. These influences may have had some impact on their perceptions of compassion, subsequently contributing to the data that they shared throughout the research process. However, in spite of these influences, individuals shared experiences that were based on their personal experiences of care rather than their experiences within the professional health focused context. This is evident in the data extracts that were provided in Chapter 5 to support the research findings. Rather than a limitation, the professional experiences the participants had encountered perhaps provided enhanced insight and understanding of the issues, enabling them to articulate their perceptions of compassion with relative ease. As discussed earlier, individuals construct perceptions of phenomena from diverse experiences in the social world, which the constructivist approach to grounded theory acknowledges to be ‘embodiment’ (Clarke, 2005). Embodiment was explored in Chapter 3 of the

thesis to clarify potential influences on the research from the outset, and was identified to be a factor with potential to influence the way in which both myself, and the participants, constructed perceptions of compassion. Rather than a limitation, this supports the efficacy of adopting a constructivist approach to the grounded theory research that was implemented, thus enhancing transparency and trustworthiness of the study.

As discussed in Chapter 3, interpretive research approaches generate knowledge that is dynamic and subjective, constructed by individuals within the context of their social environment (Polit-O'Hara, 2004) and perceived within the frame of reference of those who are being researched (Burrell and Morgan, 1979). Constructivist grounded theory generates understanding of a phenomenon via collaborative research relationships (Charmaz, 2006, 2014), which are founded on a relativist ontology to acknowledge multiple realities and a subjectivist epistemology to support the co-construction of knowledge (Denzin and Lincoln, 2003). As a result of these multiple subjective realities, it is not possible to generalise the findings of my research to the wider population. Indeed, constructivist grounded theory does not seek to achieve this, rather it seeks to generate understanding of multiple and subjective realities of the social world (Charmaz, 2014).

Williams (2000) asserts that 'moderatum generality' can, however, be explicated from interpretive research. In particular, generality relates to the fact that research conducted within one social group, can generate resonance with other social groups which share historical and contextual similarity. Therefore, the new knowledge

generated from my research provides a rich and detailed insight into individual perceptions of compassion that can offer propositional generality and resonance to other individuals in similar contexts. *The Model of Compassion for Humanising Nursing Care* that was constructed from this research provides exactly this. The model provides a set of propositional theoretical concepts which offer a platform from which to understand compassion across other groups of individuals, nurses and healthcare professionals within similar contexts of care. Moreover, it offers a foundation from which to initiate opportunities for further exploration of the emerging theoretical concepts through empirical research, such as those identified earlier as recommended avenues for future investigation.

6.8 Chapter Conclusion

This chapter has presented a comprehensive discussion of the research findings, which represent individual perceptions of compassion within the context of nursing. The discussion elicited links with existing knowledge, clarified new insights into compassion and considered connections to the theoretical influences that underpin the thesis. A variety of unique aspects of compassion were uncovered, providing an original contribution to the knowledge that currently informs compassion within the context of nursing. The chapter culminated in presenting *The Model of Compassion for Humanising Nursing Care*, which proposes the grounded theory that was constructed from this study. Throughout the discussion, a range of implications emerged which have been addressed with a series of proposed recommendations for future practice, policy, education and research. Subsequent to this, an exploration of the limitations of the study was also presented.

The discussion has presented a unique and original insight into compassion within the context of nursing, exclusively drawn from the perceptions of individuals who have experienced nursing care. As a result, this thesis has provided an innovative model of compassion that can offer potential resonance with similar individuals, nurses and healthcare professionals across similar care contexts. *The Model of Compassion for Humanising Nursing Care* provides a set of propositional assertions from which compassion can be more fully understood, whilst also providing a propositional framework which can support compassion to flourish in the care context. Overall, the chapter demonstrates that the research question and objectives that were posed at the outset of this thesis have been addressed, through a comprehensive investigation to explore what individuals perceived compassion to involve as a result of their personal experiences of nursing care. The following chapter concludes the thesis.

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Chapter 7: Summary and Concluding Thoughts

7.1 Chapter Introduction

This chapter concludes the thesis with a summary of significant aspects of the study.

The impetus for research, the research question and objectives, the influencing philosophical and theoretical tenets and the research methods that were implemented are revisited. The key findings and grounded theory constructed from the research are summarised, recommendations for practice and limitations of the research are briefly outlined, and the original contribution to knowledge that this thesis provides is clarified. The chapter concludes with a proposed plan for dissemination of the findings and considers the way forward for compassion in the context of nursing. The chapter draws together the significance of the thesis to compassion in nursing and provides a précis to delineate the entire work.

7.2 Impetus for Research

The doctoral research presented in this thesis primarily arose from a personal desire to uncover a more comprehensive understanding of compassion in the context of nursing. As outlined in Chapter 1, at the outset of my doctoral journey I was in a role to recruit and select the most appropriate candidates to embark on an undergraduate adult nursing programme. Personal questions began to emerge as a result of my engagement with this selection process, specifically relating to the reasons why particular candidates were chosen to embark on the programme, over others. Reflecting on this, I concluded that selection was often dependent on the qualities and characteristics of the candidate, particularly in relation to their ability to demonstrate compassion. Recognition of this laid the foundations for an ardent interest in compassion and a desire to understand it from a scholarly perspective.

At the same time of eliciting my interest in compassion a range of publications were also emerging, reporting a series of negative experiences of nursing care which seemed to reflect an incipient lack of compassion. These reported negative experiences of compassion gained high profile attention in the media, creating a discourse to suggest that compassion in nursing was an aspirational aspect of the role in contemporary practice, due to an emerging 'compassion deficit'. In response to this, a widespread political and professional reaffirmation transpired, re-endorsing the notion that compassion continued to be a core philosophy of nursing. However, despite this reaffirmation of compassion, there was limited articulation in the emerging political and professional literature to elicit what compassion involved.

A stepped approach was adopted to review the literature that was presented in Chapter 2, commensurate with the ethos of grounded theory research. This identified that although there was a range of conceptual analyses, discursive commentaries and political and professional guidance to inform understanding of compassion, there was a limited range of empirical research. In particular, there was a dearth of empirical research to explore compassion, exclusively from the perceptions of individuals who had experienced nursing care within the UK context. A wider range of literature was explored in relation to concepts that emerged to be significant throughout the research process. This broader review explored literature from the domains of nursing and other disciplines, however, the focus of this evidence was not specifically centred on perceptions of compassion. A collation of the review of this extensive range of literature identified a significant gap in the contemporary empirical evidence base, and highlighted that an exclusive exploration of individual

perceptions of compassion within the context of nursing, was worthy of further investigation. This reinforced the impetus for the focus of my research and ensued in the development of the primary research question and objectives, which were introduced in Chapter 1, revisited in Chapter 6 and are reiterated again below.

7.2.1 Research Question

What do individuals perceive compassion to involve and how do their personal experiences of nursing care contribute to this?

7.2.2 Research Objectives

- To explore individual experiences of care to elicit perceptions of what compassion involves.
- To uncover particular nursing care activities, behaviours, qualities or characteristics that may be perceived to be compassionate.
- To explore the potential for contexts and environments of care to influence experiences of compassion.
- To develop a propositional grounded theory which offers an original contribution to understanding compassion in nursing.

7.3 Influencing Philosophical and Theoretical Tenets

The research question presented above clearly identifies that the focus of my study was centred on gaining insight into compassion through the perceptions of individuals who had personal experience of nursing care. Although the focus of this question was informed by the identified gap in research knowledge, it was also influenced as a result of my personal world view. As a result of extensive professional nursing experience, personal experiences of nursing care and observation of care delivered to family members, I had developed the view that

compassion had varied meaning amongst individuals. I determined that this was influenced by the subjective experiences that individuals had encountered with nurses and others in society, exemplified through interactions occurring within a range of contexts in the social world.

As discussed in Chapter 3, acknowledgment of this led me to select an interpretivist research methodology, underpinned by the theoretical influences of symbolic interactionism (Mead, 1934; Blumer, 1969) and social constructionism (Berger and Luckman, 1966), thereby seeking to elicit the subjective realities of individuals who had experienced nursing care through their interactions with nurses in a variety of care contexts. Commensurate with these theoretical influences, a grounded theory research methodology was implemented, which was underpinned by a constructivist approach. This methodological approach enabled me to acknowledge that I was unable to fully separate my existing knowledge, experience and embodiment from the research process. Constructivist grounded theory recognises that the researcher's prior knowledge, experience and insight is key to the generation of new knowledge. Furthermore, it acknowledges that new knowledge is generated through a process of co-construction to represent multiple subjective realities, which emerge through a collaborative relationship between the researcher and the individuals they are researching. The constructivist grounded theory approach of Charmaz (2010, 2014) provided the foundation from which the research evolved.

7.4 Research Methods

As discussed in Chapter 4, a target sample population of thirty-six participants was identified from an existing group of individuals who had highlighted themselves as having experience of nursing care, and were in an established role to share their narratives with undergraduate students. Following ethical approval to commence the research, an invitation to participate, accompanied by detailed study information, was disseminated to prospective participants. Sixteen prospective participants provided their initial consent to contribute to the research and were subsequently requested to complete an initial sampling questionnaire, providing the basis from which to assimilate a sampling matrix. This matrix supported decisions related to selection of the initial participant and early theoretical sampling. However, as data collection progressed, the sampling matrix proved to be of less utility and data analysis guided theoretical sampling decisions to advance the development of the emerging findings. Data was collected through eleven individual interviews, a focus group discussion and three additional individual interviews. This resulted in fifteen data collection episodes over the course of the study, with a final sample of eleven individuals.

Data was analysed using initial, focused and advanced coding techniques to construct the data categories, and was supported by constant comparative analysis. Advancing theoretical sensitivity supported analysis, and as the data categories reached theoretical saturation data collection was ceased. A series of theoretical sorting iterations and advanced analysis using a ‘messy map’ technique supported assimilation of the findings into four data categories and a core category. Reflexivity

was an integral component of the entire research journey and supported progression throughout all phases of the study.

7.5 The Model of Compassion for Humanising Nursing Care

As a result of in depth analysis of the data, four major categories and a core category were identified: *Self-Propensity for Compassion*, *Attributes for Compassion*, *Socialising for Compassion*, *Conditions for Compassion* and *Humanising for Compassion*. Each data category was presented in detail in Chapter 5 and supported with extracts from the data. It was evident that there was a complex interdependent relationship between the categories, with factors from one category having potential to influence another. Equilibrium of the categories was noted to be essential to facilitate humanising approaches to care, the core and central aspect that individuals identified to fundamentally embody compassion. Reflexivity advanced conceptualisation of the findings, through consideration of the data categories in relation to the primary research question and the underpinning theoretical influences of the thesis. This was supported by a conceptual mapping activity, which led to the conclusion that participants perceived compassion to involve five elements of compassion: *Character for Compassion*, *Competence for Compassion*, *Motivation for Compassion*, *Connecting for Compassion* and *Action for Compassion*. These elements of compassion were subject to influence by three overarching principal dimensions of compassion: *Self*, *Interactions with Others* and *Situational Contexts*.

The principles of nature and nurture were noted to be significant to the findings.

Rather than competing against one another, nature and nurture seemed to

complement one another through a complex interdependent relationship between biological, psychological and socio-contextual factors. This complex relationship implicitly influenced individual perceptions of compassion in nursing, suggesting that compassion in nursing could only be more fully understood through a biopsychosocial lens. This concept, together with the key concepts derived from the findings, provided the foundation for the discussion that was presented in Chapter 6 and the grounded theory that was constructed from this study. *The Model of Compassion for Humanising Nursing Care* (Figure 18, p294) provides an original contribution to the contemporary evidence base that informs compassion. It is underpinned by a biopsychosocial perspective which expounds the complexity of what compassion involves, identifying key elements and dimensions of compassion that can affect equilibrium or disequilibrium and therefore, humanising or dehumanising approaches to nursing care.

The model proposes that individual experiences of humanising approaches to care are the central embodiment of what compassion involves. Compassion is enabled when nurses exhibit character, competence, motivation, connecting and action for compassion. Nurses require a character that has inherent proclivity for compassion, as a baseline foundation from which to further cultivate competence and motivation for compassion. Compassion is demonstrated when nurses exhibit compassionate attributes and interactions, and they are motivated to connect with the individuals for whom they are caring to implement action for compassion. This series of five elements of compassion, all need to be present in a state of equilibrium to enable humanising approaches to nursing care. When there is disequilibrium of the five

elements, compassion can be inhibited and dehumanising approaches to nursing care can emerge.

The principal dimensions of compassion relating to *Compassionate Self*, *Compassionate Interactions with Others* and *Compassionate Situational Contexts* influence the elements of compassion at an overarching level. *Compassionate Self* is dependent on a baseline level of character, competence and motivation for compassion and is a pre requisite for nurses, providing a foundation of proclivity from which compassion can be cultivated further. Cultivation of compassion occurs through education in the home, school and nurse education contexts, as well as through role modelling, leadership and reciprocal interactions in the care context. Throughout the discussion in Chapter 6, it was evident that social processes, interactions and experiences in the social world were a powerful means to influence the nurse's sense of *Compassionate Self* and thus, action for compassion through humanising approaches to nursing care.

The situations and contexts within which the nurse functions can exert influence on *Compassionate Self*. This involves factors related to human resources, systems and processes of contemporary practice and the organisational culture, particularly in terms of how they enable or inhibit compassion. Addressing approaches to enable these factors can create *Compassionate Situational Contexts*, within which compassion can flourish. The principal dimensions of compassion are dependent on a state of equilibrium, in order to facilitate equilibrium of the elements of compassion. Ultimately, equilibrium of the elements and dimensions of compassion

can enable humanising approaches to nursing care, whilst disequilibrium can enable dehumanising approaches to care. As already identified, humanising approaches to care represented the core aspect of what compassion fundamentally embodies for individuals experiencing care.

Individuals were noted to construct their perceptions of compassion as a result of experiences and interactions in the social world with nurses and a wider range of others, which the data reflected as multiple and subjective realities of what compassion involved. This reflected accordance with the underpinning theoretical influences of the thesis (Mead, 1934; Berger and Luckman, 1966; Blumer, 1969) and supported the fit of constructivist grounded theory. Eliciting multiple and subjective realities is the core aim of the constructivist approach to grounded theory research, thereby providing a rich and detailed insight into the phenomenon under investigation (Charmaz, 2006, 2014). Despite the multiple and subjective realities of compassion, there was clear accordance across the data to indicate what individuals perceived compassion to involve. This rich and comprehensive insight supported the construction of *The Model of Compassion for Humanising Nursing Care*, which presents a grounded theory that can afford an original contribution to the evidence that currently informs compassion within the context of nursing.

7.6 Recommendations

Throughout the discussion of the findings in Chapter 6 to elicit links with existing knowledge and clarify new insights which further inform compassion in the context of nursing, implications for practice emerged. In order to address these implications,

a series of recommendations were proposed. These recommendations are briefly outlined below.

- Implement recruitment and selection strategies to identify baseline ‘potential’ for compassion.
- Develop organisational cultures within which nurse leaders role model compassion, inspiring and motivating other nurses to replicate.
- Adopt strategies to support nurses to manage technical and fundamental aspects of the role with equal parity.
- Review staffing levels, particularly in relation to Registered Nurse skill mix ratios.
- Develop social policy to address compassion as a collective value across society, particularly in early years education in schools.
- Actively include individuals who have experienced care in policy development related to health and nursing care practice.
- Focus on developing attributes for compassion in formal nurse education with equal parity to clinical and technical skills.
- Promote the implementation of ‘momentary vignettes’ for compassion as a minimum standard of compassion.
- Strengthen role modelling in the care context through selecting experienced nurses with affinity for compassion to support novice nurses.
- Identify opportunities for further research to investigate *The Model of Compassion for Humanising Nursing Care* with other individuals and stakeholders in other care contexts.

- Conduct further research to explore unexplained emerging issues related to nurses who exhibit an enhanced disposition for compassion.

7.7 Limitations of the Research

In accordance with transparency and the aim to establish credibility and trustworthiness, key aspects were highlighted as potential limitations of the research in Chapter 6. These are briefly outlined below.

- Individuals sometimes drew on care experiences with other health care professionals or general life experiences, thus creating some challenges to delineate experiences specifically related to Registered Nurses. However, in all cases individuals proceeded to translate these diverse experiences to their perceptions of compassion in nursing, commensurate with the theoretical influences of the thesis.
- The target sample population were in an established role to share experiences with undergraduate students, so may have had an ulterior motive for participating in the research. However, as a result of this experience, the sample demonstrated a profound level of reflection which contributed to generating a rich insight into their perceptions of compassion.
- Some members of the sample were identified as being retired Registered Nurses or members of public involvement forums and local voluntary agencies. Although these experiences may have contributed to the construction of their perceptions, the data they shared was based on personal experiences of care, rather than professional experiences of care.
- Interpretive research is unable to claim generality to the wider population of the social world. However, it can offer ‘moderatum generality’ (Williams,

2000) to other similar individuals, nurses and healthcare professionals who share historical and contextual similarity, providing a platform from which further research opportunities can ensue.

7.8 Original Contribution to Knowledge

Throughout the discussion presented in Chapter 6, originality of the thesis findings was explicated in terms of how it contributes to the existing knowledge that currently informs compassion within the context of nursing. The key aspects of this original contribution are reiterated below.

- This thesis provides the sole constructivist grounded theory study to exclusively explore the perceptions of individuals who have experienced nursing care within the northern region of the UK nursing context.
- The findings are considered through a biopsychosocial lens, utilised to support understanding of the complementary forces of nature and nurture in relation to the biological, psychological and socio-contextual factors that emerged from the findings.
- The findings identified five elements of compassion, representing what individuals perceived compassion to involve, and three principal dimensions of compassion which exert overarching influence on these five elements of compassion.
- Innovative insights into compassion were gained through identification of factors related to an enhanced disposition for compassion, personality and career congruence, equality in the care relationship and reciprocity between agents, which require further investigation through additional future research.

- The thesis explicates the proposition that humanising approaches to care fundamentally embody compassion, an original claim within the current body of knowledge that specifically informs compassion.
- The thesis constructs a unique grounded theory, presented as *The Model of Compassion for Humanising Nursing Care*. This model provides an innovative framework from which to understand compassion, that can provide a foundation for further research with other individuals, nurses, healthcare professionals and stakeholders in other care contexts.

7.9 Disseminating the Findings

Disseminating the research findings to diverse audiences is an essential aspect of research practice (Holloway and Freshwater, 2007). Dissemination can assume various forms, such as publishing in peer reviewed journals, presenting at national and international conferences or simply sharing findings with relevant stakeholders in the work place (Silverman, 2005). As discussed in Chapter 1, immediately prior to commencing my research, I published an article in the British Journal of Nursing (Appendix 1), commencing a strategy for dissemination from the outset. During the course of the doctoral journey, I have disseminated early research findings at a variety of conferences. These previous dissemination activities are outlined in Table 6 below.

Table 6: Dissemination Activity to Date

Date	Conference	Activity
June 2014	Northumbria University Research Conference	Poster presentation (Appendix 21)
July 2014	Association of Medical Humanities “The Art of Compassion” Conference	Oral presentation (Appendix 22)
October 2014	North East Post Graduate Research Conference	Oral presentation (Appendix 23)
July 2015	Northumbria University Post Graduate Researcher Conference	3-minute thesis (Appendix 24)

In the post-doctoral phase, dissemination activity will be continued. This will be achieved through provisional plans to develop articles for publication in international peer reviewed research journals, present *The Model of Compassion for Humanising Nursing Care* at relevant international conferences, present the findings to stakeholders and partners within the university context and finally, to share the findings with the individuals who volunteered their time to participate in the research.

7.10 Post-Doctoral Research

Charmaz (2014) highlights that an emerging grounded theory provides a preliminary foundation of knowledge, which researchers can build upon through further research activity. *The Model of Compassion for Humanising Nursing Care* provides such a foundation, however, in order to strengthen this, further empirical investigation is required. This will be achieved through post-doctoral research to explore the fit and resonance of the model with other stakeholders such as Nurse Academics, Registered Nurses, Student Nurses, Allied Health Professionals and individuals experiencing care in other care contexts. Further empirical research will enhance the credibility of

the model, with the aim to advance the legitimacy of the grounded theory that has emerged from this thesis and support its acceptance across wider national and international care contexts.

7.11 The Way Forward

As identified in the introductory chapter, compassion is the most precious asset of the nursing profession, originating in the United Kingdom from theological traditions of caring for the sick and attributed to professional nursing through the influences of Florence Nightingale. The research that has been presented in this thesis identifies that individuals have sustained affinity with these historical origins of compassion, perceiving that compassion remains an essential aspect of nursing. To illustrate this, the findings clearly highlighted that individuals continued to expect compassion as an integral part of their nursing care experience, through perceptions that had been constructed as a result of social processes and interactions experienced in the social world. However, the findings indicated that there was evidence in the data to highlight that some nurses failed to exhibit compassion in their practice and as a result, implemented dehumanising approaches to nursing care. Although this evidence appears to support the emerging discourse to suggest that there is a ‘compassion deficit’ in nursing, the majority of professional nurses would refute this and pledge allegiance to the claim that compassion continues to be a core philosophy that underpins their practice. Indeed, this claim was also reflected in the findings which indicated that many nurses were able to exhibit compassion in their practice and as a result, implemented humanising approaches to nursing care.

The findings identified that the advancing modernity of professional nursing practice, and the social world in general, have exerted some level of influence on compassion in the contemporary context. Despite the historical links of compassion to theological influences, compassion should now be founded on secular values. This claim challenges nurses, and society in general, to embrace compassion as a collective approach that is afforded to all, embedding compassion as a culturally accepted norm across the social world to recognise the humanity that members of society share together. *The Model of Compassion for Humanising Nursing Care* proposed in this thesis, provides a grounded theory that can support and guide an approach to embed compassion in future nursing practice, and wider aspects of social life. It also provides a theory that may have resonance with other health care professional groups, across other contexts, both nationally and internationally. The grounded theory presented in this thesis demonstrates that the research question and objectives that were identified at the outset have been addressed, through a comprehensive exploration of individual perceptions of compassion within the context of nursing. As a result, this has elicited a range of activities, behaviours, qualities and characteristics that individuals perceived to be compassionate and illustrated the potential for the contexts and environments in which care occurs, to influence this.

Compassion is indisputably the most precious asset of the nursing profession, and as such, needs to be nurtured and cultivated in order to sustain a sense of shared humanity between nurses, individuals experiencing care and other agents across the social world. Compassion needs to be an integral aspect of contemporary nursing

practice, exhibited at some level to all individuals experiencing care, in whatever context they may be experiencing it. If the core philosophy of compassion is not sustained as an integral dimension of contemporary practice, the fundamental essence of professional nursing may begin to wane.

“Compassion is not religious business, it is human business, it is not luxury, it is essential for our own peace and mental stability, it is essential for human survival”

Dalai Lama XIV

Appendices

Appendix 1: Published Article

Exploring compassion: implications for contemporary nursing. Part 1

Collette Straughair

Abstract

The origin of compassion is firmly rooted in religious ideologies. In 19th century Great Britain, Christianity was the prominent religion and scripture advocated that followers should always be compassionate in their deeds and actions. Florence Nightingale was a Christian and translated her ideals into the characterization of the professional nurse. The image of the ministering angel, performing the work of God, was perpetuated for some time. However, as the profession of nursing advanced to develop evidence-based practice, some of the ethos of the compassionate nursing character was seemingly lost in favour of technical skills. This is supported by evidence suggesting that nurses have a decreased affinity with the ethos of altruism. Recent reports have highlighted negative patient experiences which reflect a clear lack of compassionate nursing care. This has led to a variety of documents re-endorsing the concept of compassion as a core and fundamental nursing value. This has raised several issues for nursing practice which require due consideration if the profession is to restore the image of the compassionate nurse, technically skilled and clinically effective, equipped with the appropriate skills, knowledge, values and attitudes to fulfil the pledges to respond to patients with humanity and kindness and to deliver high-quality compassionate care.

Key words: Compassion ■ Patient experience ■ Drivers for compassion ■ Florence Nightingale ■ Implications for practice

The long-held image of the compassionate nurse is at risk. As the profession of nursing has developed, the concept of compassion continues to underpin its core essence, as is evident in the Nursing and Midwifery Council (NMC) professional standards on treating people as individuals, with respect and in a kind and considerate manner (2008). However, the effectiveness of this has been questioned and it has been suggested that compassion in nursing is often aspirational, rather than a true reflection of practice (Burdett Trust for Nursing, 2006; Mooney, 2009). Evidence has highlighted concerns about poor standards of nursing care

and a lack of compassionate action (The Patients Association, 2009; Mid Staffordshire NHS Foundation Trust Inquiry, 2010a; b; Parliamentary and Health Services Ombudsman, 2011). This has emphasized the need for the profession to re-endorse the concept of compassion (Department of Health (DH), 2010a; b; Royal College of Nursing (RCN), 2010). However, Schantz (2007) purports that the true concept of compassion is elusive to the profession of nursing and the moral dimension has been eroded to such a degree that it could be considered an optional component of nursing practice.

Throughout history, the art of compassion has been practised by those responsible for caring for the sick. Engaging in compassionate deeds or actions with the sick or those in need was an act of striving to become God-like and considered to be a prerequisite to salvation (Kapelli, 2008a). This compassionate religious ideal was perpetuated for centuries (Dossey, 2007). However, as society developed in Great Britain and the foundations of nursing were laid, the responsibility for caring for the sick shifted away from the control of religious orders into the developing realms of professional nursing practice. As a result, nurses were attributed with the challenge of meeting these historical, theological ideals and regarded as angels of mercy, striving to deliver compassionate care (Bingham, 1979).

This two-part article explores the concept of compassion and considers the implications for contemporary nursing practice. Part 1 will focus on the origins of compassion from a theological and early professional nursing perspective. Specifically, the theological discussion will focus on Christianity as this was the prominent faith in 19th century Great Britain when Florence Nightingale paved the way for the profession. The ethos of compassion in nursing from a contemporary perspective will then be discussed before considering the current problems as identified through a variety of negative patient experiences. Part 2 will outline current political and professional drivers for compassion in nursing, discuss definitions of compassion and consider the implications for contemporary nursing practice.

Compassion and Christianity

It has been argued that the representation of the compassionate God in scripture and the message to followers to practice this moral virtue underpins the core value of compassion in nursing today (Kapelli, 2008a; b). She claims that Christian scripture illustrates examples of the compassionate God, which provide moral direction to followers of the faith (2008a). She also discusses the parable of the Good Samaritan and highlights its influence in teaching Christians to be compassionate in their actions. Arbuckle (2007) argues that the inherent message of the Good Samaritan is that compassion should be the

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universal standard. Armstrong (2011) further elaborates this key message and highlights the principle of the Golden Rule as the key philosophical message of Christian scripture:

‘always treat others as you would wish to be treated yourself’ (Armstrong, 2011: 1)

Pope Benedict XVI (2005) supports this further in his *Deus Caritas Est* encyclical letter in which the parable of the Good Samaritan is cited as a model for holistic care: care that meets the needs of all, regardless of background. Arguably, it is this compassionate ideal that has permeated nursing philosophy. Bradshaw (2011) agrees, stating that the development of the compassionate character was instrumental in attributing the profession of nursing with the ethos of compassion. As society developed in the 19th century, so did the profession of nursing; caring for the sick moved from the religious domain to the realms of professional nursing (Dingwall et al, 1988). Nightingale's role and the translation of her personal Christian values into a vision for nursing and the characterization of the professional nurse has proved instrumental in contributing to how nurses are viewed in society today.

Compassion and early professional nursing

In Great Britain, care provision was often dominated by religious orders that lacked medical knowledge and so, were often only able to minister spiritual comfort (Bingham, 1979). However, over time, responsibility for care of the sick was passed to parishes, families, handy women, medical attendants and charitable hospitals (Dingwall et al, 1988). Nurses at this time were poorly educated and often represented in the literature as immoral, slovenly drunkards (Rafferty, 2011). An example of this is Dickens' Sairey Gamp in *The life and adventures of Martin Chuzzlewit* (1844). However, Nightingale was instrumental in changing this perception and laying the foundations of the role of the professional nurse as we understand it today. She developed a personal interest in nursing as a result of what she termed, a 'calling from God'. Following 3 months of nurse training in Germany, she became superintendent of a gentlewoman's hospital in Harley Street and, as a result, was asked by the British Government to support the care of wounded soldiers in the Crimean War (Bingham, 1979). During this time, she began to develop her ideas around infection control, sanitation and fundamental nursing care. On her return to Great Britain, she was asked to set up the first ever secular nursing school (Abel-Smith, 1960). Nightingale translated her personal Christian ideals into the professional practice of nursing and identified the moral and religious virtues required in her *Notes on Nursing* (1859):

‘she [the nurse] must be a religious and devoted woman; she must have respect for her own calling, because God's precious gift of life is often literally placed in her hands...she should bring the best she has, whatever she has, to the work of God's world’ (Nightingale, 1859: 49, 53)

Nightingale also discussed the concept of suffering in the sick, highlighting that nurses must strive to alleviate

this through acts of compassion (Nightingale, 1859: 56). Rafferty (2011) claims that *Notes on Nursing* reflects the value Nightingale placed on compassion. This portrayal of the compassionate character was the primary ethos of nursing. As nurse education developed through the 20th century, the notion of compassion was perpetuated, with various nursing professionals highlighting the moral virtues of the professional nurse: kind, compassionate and technically competent (Bradshaw, 2011). However, as nursing became more evidence based, the traditional vocational image seemed to decline in favour of technical skills and the ethos of compassion as an essential professional nursing virtue appeared to have eroded (Schantz, 2007).

Compassion and contemporary nursing

Baughan and Smith (2008) assert that individuals enter the nursing profession because they want to deliver high-quality, compassionate care. Eley et al (2010) support this assertion through their research in Australia demonstrating that student and qualified nurses identified the key influencing factor driving their decision to enter nursing as the motivation to care for others. Further evidence from Ditommaso et al (2003) supports this and highlights that Canadian student nurses identified a desire to care for people in need as the primary reason for entering nursing. However, Cho et al (2010) showed that of 40 student nurses in Korea who had chosen to enter the nursing profession, not one identified the altruistic quality of desiring to care as a motivating factor, citing aptitude, job security and salary instead.

Altruism

Johnson et al (2007) support the outcomes identified by Cho et al (2010) and suggest that the value of altruism has been eroded over past decades. Johnson et al (2007) conducted a comparison of student nurse values from data collected in 1983 and 2005 in the UK. Student nurses completed an attitudinal questionnaire at the start and end of their programme, using a Likert scale to rank their agreement — disagreement with a series of value statements. In 1983, high levels of affinity were noted in relation to the ethos of altruism at the start of the programme, however, this declined significantly by the end of the programme. Johnson et al (2007) concluded that this was because of the process of professional socialization, whereby students internalize the values and attitudes of the organizational subculture, resulting in a subsequent reduction in idealism. In contrast, students in 2005 had a significantly lower affinity with the ethos of altruism at the start of their programme, reflecting an overall decrease in altruistic values since 1983. Johnson et al (2007) suggested that this may be owing to an overall decline in altruism in society.

Miers et al (2007) further echo this decline and provide evidence that students entering nursing are less likely to cite altruism as a motivating factor than students entering alternative healthcare professions. A prospective survey was conducted of 821 UK university healthcare students at the point of entry and 560 at the end of their programme to establish the motivating factors for choosing their profession. Participants included healthcare students from

all branches of nursing, midwifery, radiography, diagnostic imaging, physiotherapy and occupational therapy. On entry to the professional programme, an average of 56.6% of all participants cited altruism and 44.0% a desire to help others as motivating factors for entry. However, adult nurses were seen to report altruism significantly less frequently than those entering other healthcare professions such as physiotherapy and radiography. On qualification, the average number citing altruism as a motivating factor reduced, with a significant decline noted in mental health and learning disabilities nursing. This suggests that over the course of the programme, nursing students had become even less idealistic about altruistic values than other health professionals. Bolan and Grainger's (2009) nursing attitude questionnaire administered to Canadian student nurses supports this; it demonstrated a significantly decreased affinity of student nurses in relation to the value statement that nurses are kind and compassionate.

Firth-Cozens and Cornwell (2009) suggest that a variety of reasons may be responsible for such a decline in altruism, including the evolving role of the nurse, high levels of stress and burnout, organizational issues related to the dynamic nature of modern day health care and the influence of nurse education (Figure 2). Factors such as these, along with the general decline, will potentially affect levels of compassionate activity.

The problem with compassion

The Care Quality Commission (CQC) (2011a) highlighted that in a recent survey of 66 000 NHS inpatients, achieving a response rate of 50%. A total of 78% rated the overall care received as excellent or very good, however, 2% were noted to rate the care as poor. Also, 74% percent indicated that they always had trust and confidence in the nurse and 79% believed they had been treated with respect and dignity, whereas 3% had no confidence or trust in the nurse or indicated they had not been treated with dignity and respect. Although a minority of patients held a negative view on nursing care, the fact that patients perceive care to be poor or lacking in respect and dignity still gives rise for concern.

Proctor (2008) suggests that in general, across the NHS, nurses are striving to deliver high-quality compassionate care; however, there are instances of clinical areas failing to meet the required professional standard in terms of compassionate nursing care. These instances are the examples that have been highlighted recently as evidence of poor nursing care that lacks the essence of compassion. Goodrich and Cornwell (2008) suggest that even in an organization as vast and complex as the NHS, achieving complete patient satisfaction should remain a professional aspiration.

Poor standards of care

The Patients Association (2009) highlighted serious concerns as a result of reports from relatives and carers relating to:

'the dreadful, neglectful, demeaning, painful and sometimes downright cruel treatment their elderly relatives had experienced at the hands of NHS nurses' (The Patients Association, 2009: 3).

Patient stories in the report are detailed and emotive.

They indicate an extremely poor level of nursing care that contravenes all the philosophies, values and moral codes underpinning nursing. These experiences indicate a disregard for dignity resulting in seemingly compassionless care.

In 2010, the Mid Staffordshire NHS Foundation Trust Inquiry published their findings on the care received by patients during the period of January 2005 to March 2009 (2010a; b). A total of 113 oral witness testimonies were heard from members of the public and staff, which provided persuasive evidence to support the concerns raised owing to the striking similarities of accounts of poor nursing care, lack of dignity and the unnecessary suffering of patients. Significant concerns were raised about nurses' failure to respond to requests for assistance to use the toilet, resulting in episodes of incontinence and patients being left in soiled bed linen for long periods of time; high incidences of patient falls; lack of attention to patients' personal hygiene; failure to provide food, or when it was provided, limited assistance to vulnerable patients to unwrap it, cut it or feed themselves. The Inquiry concluded that, overall, the nursing care reflected a very poor standard, was lacking in compassionate and caring action and had resulted in degrading and inhumane treatment of patients who were at their most vulnerable, often in the last days of their life. The Inquiry indicated that, in some instances, it appeared that the staff, themselves, were uncaring and uncompassionate. However, they did identify that in the majority of cases, there was an inherent staffing issue and underlying organizational culture that had an immense impact on nurses' abilities to perform their true compassionate and caring roles. Many accounts of the neglect and mistreatment were harrowing and witnesses used emotive phrases to reflect this (Figure 3). As a result of the lack of compassionate care, the Inquiry made several recommendations, which included the need to ensure appropriate education and training of staff, regular monitoring of performance, adherence to published principles of nursing care and more effective management and leadership of nursing staff.

More recently, The Parliamentary and Health Care Ombudsman (2011) presented ten case study investigations of patients who had received extremely poor nursing care that clearly lacked compassion. The Health Care Ombudsman (Abraham, 2011) states that there are many nurses working in the NHS who deliver high-quality compassionate care, however, she argues that this is not universal and the recurring themes identified through numerous complaints are what prompted the *Care and Compassion?* report (The Parliamentary and Health Care Ombudsman, 2011). The report highlights the failure of NHS organizations and nurses to deliver care that reflects the articulated core values and principles of the NHS Constitution (DH, 2010a). Of the ten case studies presented, nine individuals died during or shortly after the events, the circumstances of which, the Ombudsman notes, contributed immensely to their relatives' distress.

All the studies presented are harrowing but, sadly, they are true and reflect a complete disregard for the fundamentals of dignity and compassion, and are sufficient to shock nurses into action that strives to put right what is going wrong. The Parliamentary and Health Care Ombudsman (2011) highlights that the case studies presented are indicative of

both individual and organizational failures to recognize the humanity and individuality of the patients involved and respond appropriately with compassion and sensitivity, ultimately reflecting the indifference of staff attitudes to deplorable standards of nursing care.

Unfortunately, these reported patient experiences do not seem to reflect isolated or infrequent events. In recent months, the CQC (2011b) has published findings, which suggest that a proportion of NHS hospitals are not meeting essential standards of care for older people in relation to being treated with dignity or respect and meeting individual nutritional care needs. Every day, there seems to be new evidence to suggest that some patients continue to experience a lack of compassionate care. Online patient stories, media coverage and anecdotal evidence of nursing care that do not always fulfil the fundamental principle of compassion are now worryingly common. It is for this reason that a range of drivers from both government and professional sources have re-endorsed the core value of compassion as an underpinning principle of nursing care and highlighted the need for nurses to ensure this principle is implemented to a high standard. This has raised several implications for contemporary practice.

Conclusion

The notion of compassion in nursing can be attributed to the Christian ideals translated by Florence Nightingale into the characterization of the professional nurse. As technical nursing skills have evolved, the ethos of compassion and the concept of altruism as essential professional virtues seem to have been eroded. A variety of negative patient experiences have highlighted problems with compassion, reflected in reported instances of poor standards of nursing care. As a result, a range of political and professional drivers re-endorsing the concept of compassion have emerged. Part 2 of this article will outline the political and professional drivers for compassion, explore definitions of compassion and discuss the subsequent implications for contemporary nursing practice.

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Conflict of interest: none

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- 'the staff were blasé...stodgy'
- 'it was a lack of anything: compassion'
- 'we had more compassion from the cleaner'
- 'we didn't see anyone treated as an individual'
- 'the lack of compassion was notable'

Figure 3. Witness Quotations from Evidence Heard at the Mid Staffs NHS Foundation Trust Inquiry (2010a; b)

Figure 2. Factors impacting compassion in nursing

- The values instilled in nurse education
Strong emphasis on high-quality clinical care to the detriment of focusing on humanistic aspects of care such as the importance of compassion
- A fear of distress and dying
Nurses distance themselves from the suffering of patients to avoid personal and often subconscious fears of distress and dying, eroding their ability to feel or demonstrate compassion
- Stress, depression and burnout
A result of the emotional labour of nursing, high expectations of clinical excellence, issues with the quality of the team, organizational issues related to high workload, time pressures and lack of support. This can result in depersonalization which is likely to inhibit compassion
- The wider hospital context
Factors related to shorter length of hospital stay, high bed occupancy, need to meet national targets and achieve financial goals, advancing use of technology, delegation of fundamental aspects of care to healthcare assistants, all of which can be detrimental to compassion

Adapted from Firth-Cozens and Cornwell (2009)

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KEY POINTS

- The origins of compassion can be attributed to religious influences and are evident in Christian scripture
- Florence Nightingale translated her Christian ideals in to the characterization of the early professional nurse
- Student nurses' ethos of altruism has declined over past decades, influenced by professional socialization over the course of nurse education programmes and overall reducing societal idealistic views
- A variety of factors are considered to influence compassion in nursing such as nurse education, the dynamic nature of modern day health care, organizational issues and the delegation of fundamental care delivery to healthcare assistants
- There is a range of evidence highlighting poor patient care with various examples of negative patient experiences lacking compassion

The Mid Staffordshire NHS Trust Foundation Inquiry (2010a) *Independent Inquiry into Care Provision by Mid Staffordshire NHS Foundation Trust. January 2005-March 2009. Vol 1. Chaired by Robert Francis QC.* The Stationary Office, London

The Mid Staffordshire NHS Trust Foundation Inquiry (2010b) *Independent Inquiry into Care Provision by Mid Staffordshire NHS Foundation Trust. January 2005-March 2009. Vol 2. Chaired by Robert Francis QC.* The Stationary Office, London

The Parliamentary and Health Service Ombudsman (2010) *Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People.* The Stationary Office, London

The Patients Association (2009) *Patients...not numbers, People...not statistics.* The Patients Association, London

The Royal College of Nursing (2010) *Principles of Nursing Practice: Principles and Measures Consultation Summary Report for Nurse Leaders.* RCN, London

Exploring compassion: implications for contemporary nursing. Part 2

Collette Straughair

Current political and professional drivers for compassion in contemporary nursing are an important consideration, as the profession is constantly put under the microscope by the public, the media and the Government. These issues, along with definitions and implications for contemporary nursing practice are discussed in this article. This is the second of a two-part article looking at compassion in nursing. Part 1 looked at the origins of compassion in nursing, and the importance of re-endorsing it.

Political and professional drivers for compassion

In response to the plethora of reported negative patient experiences relating to a lack of compassionate nursing care, some of which were outlined in part 1 of this article, much of the contemporary political and professional literature makes specific reference to the fundamental and essential aspect of compassion in nursing. In 2010, the Department of Health (DH) (2010a) published the NHS Constitution, which aims to establish the principles and values underpinning the health service and identify the rights of patients, public and staff with a series of pledges. One of these values relates specifically to compassion, indicating that patients can expect this as an integral component of everyday nursing care:

‘Compassion...we respond with humanity and kindness to each person’s pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.’ (DH, 2010a: 12)

This value statement represents compassion as expressed by patients, public and staff (DH, 2010a), and demonstrates a commitment to recognizing people’s suffering and actively engaging in action to alleviate it. The Prime Minister’s *Commission on the Future of Nursing and Midwifery in England* (DH, 2010b) further supports the pledge for high-quality compassionate nursing care, and highlights the role of nurses, nurse leaders and corporate boards in championing this fundamental practice. However, the report does not provide any real indication of what this entails. The DH does, however, recognize the complexity of compassion, stating:

‘Truly compassionate care is skilled, competent, value based care that respects individual dignity. Its delivery requires the highest levels of skills and professionalism.’ (DH, 2010b: 3)

Abstract

A range of contemporary political and professional literature endorse the principle of compassion in nursing as a core and underpinning philosophy fundamental to the profession. However, despite pledges to ensure that compassion lies at the heart of nursing, the concept has not been clearly defined. It is evident that uncovering the true meaning is complex and challenging owing to its subjective nature. In light of this, several implications must be considered. Effective student nurse recruitment is essential to ensure that the most appropriate individuals are selected. Contemporary marketing campaigns must be implemented, and recruitment strategies developed, which consider specific values and attitudes. Service user involvement in recruitment and selection, curriculum planning and learning and teaching strategies, and post-qualification education, can enhance nurses’ understanding of the patient perspective and make headway in embedding compassion as a core nursing value. Additionally, effective role modelling in practice which demonstrates high-quality compassionate nursing care is essential. Nurses must be adequately supported in the clinical environment to facilitate compassionate behaviours and clinical leadership at all levels must uphold political and professional pledges to achieve this. Consideration of these implications for practice is essential to ensure that nurses are able to respond to patients with humanity and kindness, and deliver high-quality, compassionate care to all.

Key words: Compassion ■ Altruism ■ Care ■ Moral code ■ Value statements

The Royal College of Nursing (RCN) (2010) elaborate further, identifying eight principles of nursing practice to highlight what patients, relatives and staff can expect. Principle A relates to compassion, and states:

‘Nurses and nursing staff treat everyone on their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.’ (RCN, 2010)

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Jackson and Irwin (2011) discussed this principle further, highlighting that patients and nurses identify it as the most fundamental aspect of nursing care. Further professional guidance on the importance of compassion is embedded in the Nursing and Midwifery Council (NMC) (2010) document *Standards for Pre-Registration Nursing Education*. These standards identify the required level of competence that student nurses must attain to enter the professional register, placing immense importance on compassion. Further calls for it to be considered as an integral part of everyday life arise from the work of Karen Armstrong through her *Charter for Compassion* (2009). Although not specifically linked to professional nursing practice, the message is clear: society is interdependent, and to ensure that humanity is fulfilled, compassion must be practised as a matter of course. Many would agree that it is this very concept that underpins the moral essence of professional nursing.

The concept of compassion has been re-endorsed as an essential and integral component of professional nursing practice, as identified in political and professional literature. Arguably, this indicates a desire to re-establish the original essence of the moral virtues of the professional nurse: kind, compassionate and technically competent (Bradshaw, 2011). However, to facilitate the implementation of compassionate care, it is imperative that nurses understand contemporary definitions of the term.

Defining compassion

Despite the current political and professional pledges to ensure that compassion lies at the heart of nursing, defining and understanding its true meaning is complex, owing to its subjective nature (Davison and Williams, 2009; Harrison, 2009; Dewar et al, 2011). Schantz (2007) maintained that compassion is the most precious asset of the nursing profession; however, the concept is not clearly defined or widely promoted in the context of contemporary nursing practice, and is further confused as a direct result of using words such as 'caring', 'sympathy', 'empathy' and 'compassion' interchangeably.

The Oxford English Dictionary (2010) defines compassion as 'sympathetic pity and concern for the sufferings or misfortunes of others'. This highlights a feeling or emotion for another individual who is suffering, but does not identify positive action to alleviate this. Schantz (2007) suggested that dictionary definitions are inadequate to explain the concept, as they merely indicate 'a vicarious participation in other people's emotions, ideas or opinions'. Schantz (2007) also said that compassion in the truest sense 'impels and empowers people to not only acknowledge, but also act towards alleviating or removing another's suffering or pain'.

Figure 1. Defining compassion

'Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion into the condition of being human.'

Source: Nouwen et al (1982: 4)

Nouwen et al (1982) elaborated on this, stating that, to be compassionate, individuals need to feel empathetic to the suffering of others, enter into the realms of this suffering, and react in such a way as to demonstrate humanity (Figure 1). Nussbaum (1996) also stated that compassion involves recognizing the suffering of others and engaging in action to alleviate it. Dietze and Orb (2000) suggested that, to achieve this, the traditional professional boundaries between emotion and reason need to be blurred, leading nurses to consider compassion as 'not what we choose to do for patients, but what we choose together with them'.

In more simplistic terms, Youngson (2008) defined it as 'the humane quality of understanding suffering in others and wanting to do something about it'. Indeed, compassion means that nurses need to see beyond the patient by recognizing his or her humanity and individuality (Cornwell and Goodrich, 2009). The literature illustrates that compassion is a human emotion, borne out of the awareness of another's suffering and a desire to alleviate this. However, as Schantz (2007) identified, original research on the concept of compassion is scarce and, until further work is undertaken, the definitive meaning is elusive. Olshansky (2007) stated that, until compassion is clearly defined, nurses will not be able to truly claim it as an integral dimension of professional practice.

Implications for contemporary nursing practice

Recruitment and selection

Effective student nurse recruitment is essential to ensure that the most appropriate individuals are selected. Students entering the profession today appear to have a decreased affinity with the notion of altruism and the concept of being motivated to care for individuals, often citing alternative reasons for becoming a nurse such as job security and salary (Johnson et al, 2007; Miers, 2007; Cho, 2010). The DH (2010b) also points out that the portrayal of nursing in society is outdated, and many still perceive the nurse to be simply that of poorly educated doctor's handmaiden. This needs to be addressed so that suitable candidates apply to join the profession.

Matutina (2008) agreed that school-age children are misinformed about the nursing role, and base their perceptions on those of parents, peers and teachers, which are often inaccurate and based on old-fashioned representations. This is supported further by Whitehead et al (2007) who identified that teenage students still held traditional views or had limited knowledge about the profession. To recruit the most appropriate student nurses, educators must ensure that contemporary robust marketing campaigns broaden public awareness of the diverse nature of nursing (Whitehead et al, 2007; DH, 2010b). In addition, nurse educators must strive to develop effective recruitment strategies which consider individual values and attitudes. Saldanha (2006) identified that higher education institutes in the UK use a range of strategies to facilitate this, including one-to-one interviews, group discussions, attitudinal surveys and emotional intelligence assessments.

Psychometric testing has been proposed as a tool to support effective student nurse selection (Gray-Roberts, 2010); however, there is much debate surrounding the value

of this. Cole (2011) suggested that psychometric testing cannot offer insight into an individual's ability to interact or communicate with patients, and also argued that poor nursing care is usually the result of organizational issues, rather than an inherent personality trait. In contrast, Gray-Roberts (2010) asserted that psychometric testing can be a useful and effective tool to identify aspects of personality, but stressed this cannot be used in isolation and should supplement traditional selection procedures.

Service-user involvement

Alternative strategies to enhance effective recruitment and selection relate to the use of service users. The NMC (2008a) support the use of service users in the recruitment and selection of student nurses, and actively encourage their participation as an indicator of good practice. Roberts et al (2010) highlighted that service users are consumers of health care, and so are well-placed to contribute to decisions relating to selection of the most suitable student nurses who are seen to demonstrate the appropriate qualities and skills. Indeed, Simpson (2006) claimed that service users bring a unique perspective to the process, which can positively complement the perspectives of academics and clinicians. This perspective arises from the ability of service users to discern good-quality compassionate care as a direct result of their personal experiences of nursing care (Altree, 2001).

Cook and Walsh (2007) identified that service users should also be involved in undergraduate nursing curriculum planning, design and participation in teaching and learning strategies. Simpson (2006) suggested that such involvement should be integral to the strategic direction of higher education institutes, ensuring that users are willing and active participants in curriculum planning, development and delivery. However, efforts must be made to ensure fairness and equity of representation to allay potential cynicism relating to the stereotypical volunteer of the articulate and middle-class individual, and to avoid organizations taking a tokenistic approach to service-user involvement (House of Commons Public Administration Select Committee, 2008). Firth-Cozens and Cornwell (2009) added that, following qualification, registered nurses should have access to continuing professional development that includes service-user narratives, to deepen their understanding of patient perspectives. If service users are involved in the teaching and learning strategies, this may help to illustrate the importance of compassion and make headway in re-embedding the concept as a core value of nursing (Firth-Cozens and Cornwell, 2009).

Role modelling

There needs to be more emphasis on the need to act as a role model to others, in terms of delivering high-quality compassionate nursing care (Firth-Cozens and Cornwell, 2009). Bandura's (1977) social learning theory states that individuals learn in the social environment through the observation of others' actions. Alain (1989) asserted that, when learners are unable to discriminate positive from negative role modelling, there is a risk they may perpetuate negative behaviours. Schon (1983) identified that, when student nurses

work with a mentor in the clinical environment, they reflect on and internalize the behaviour patterns observed.

Illingworth (2006) suggested that student nurses undergo a process of professional socialization, involving the transfer of values, attitudes and beliefs from experienced nurse to less experienced nurse. Role models can best demonstrate to student nurses that compassion is a core behaviour by showing their own commitment to the concept. In his qualitative study to identify the key characteristics of the positive role model, five categories emerged: the demonstration of high standards, taking an interest in others, being a knowledgeable practitioner, taking a responsible approach to the role and having an understanding of others (Illingworth, 2006). Demonstrating such attributes is the most appropriate way of supporting student nurses in the clinical environment. Johnson et al (2007) and Miers (2007) have shown that the concept of altruism has become less important to students, reflecting a less 'idealistic' or spiritual approach, as a result of the above mentioned professional socialization. This may be a direct result of observing role-modelling behaviours that do not always reflect and value the importance of compassion. Firth-Cozens and Cornwell (2009) advocated that acting as a role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students and less experienced staff.

Support

To enable nurses to demonstrate compassionate behaviours, appropriate support systems must be in place. Firth-Cozens and Cornwell (2009) identified stress and burnout as key factors in reducing the occurrence of compassionate care, as these can cause nurses to depersonalize patients. They championed the need to provide access to support groups and educational workshops, with a view to promoting strategies for preventing stress. Schwartz Center Rounds (Smyth, 2011) are an example of effective supportive networks, which provide a multidisciplinary forum where staff can discuss and reflect on challenging emotional and psychological situations, and gain support and insight from colleagues. Nouwen et al (1982) stated that, to be compassionate, individuals need to feel empathetic to the suffering of others, enter into the realms of this and react by demonstrating humanity. In doing this, nurses are asked to give something of themselves and, to avoid stress, burnout and compassion fatigue, formal support mechanisms are essential.

Leadership

Embedding compassion as a core value through leadership is a key consideration. The DH (2010b) highlights the importance of the ward sister's role in providing clinical leadership to support the pledge to deliver high-quality compassionate care. Furthermore, the DH (2010b) also recommends that senior nurses and corporate leaders must uphold this pledge and accept accountability for the standards of patient care, championing quality from 'ward to board'. Firth-Cozens and Cornwell (2009) suggested that corporate strategies need to consider issues related to human resources, skill mix and workload factors. Mooney (2009) discussed the role of quality indicators in nursing, highlighting the need

to develop compassion metrics, as advocated by Griffiths et al (2008). Nurse leaders also need to ensure that nurses are afforded the opportunity to reflect on their practice and maintain ongoing personal and professional development in relation to compassion in nursing. Bryant (2010) highlighted the importance of clinical supervision as a vehicle to support this. The NMC (2008b) stated that supervision enables nurses to 'identify solutions to problems, enhances understanding of professional issues and facilitates the improvement of the standard of patient care. Ultimately, effective leadership at all levels is key to ensuring that pledges to deliver high-quality compassionate care are achieved. Youngson (2008) identified modernization of services and fragmentation of care as key factors affecting compassion. He highlighted an action plan outlining the major elements he claims are required to ensure that compassion is an everyday reality of practice (Figure 2).

Further research

Currently, much of the nursing literature relating to compassion can be found in political and professional guidance, conceptual analyses and opinions. Very little original research has been undertaken to explore the concept in greater depth (Schantz, 2007).

Conclusion

Compassion in nursing is not a new concept, but is derived from ancient theological ideals that were translated by Florence Nightingale into the very essence of professional nursing. It remains an underpinning philosophy that permeates the moral codes and value statements of nursing today, and as such it should be regarded as fundamental. As the profession has evolved, there has been an increasing emphasis on developing the quality of clinical care and, as a result, the value of compassion has seemingly been eroded. Negative patient experiences demonstrating a lack of compassion in nursing have highlighted this flaw and, consequently, political and professional drivers have re-endorsed the concept as fundamental to contemporary nursing practice.

To ensure that nurses are able to deliver high-quality compassionate care, they need to be supported by effective leadership and corporate strategies that consider human resources, skill mix and workload. Nurse educators must be mindful about implementing appropriate recruitment and selection strategies, involving service users and embedding the concept of compassion into nursing curricula. Additionally, further research needs to be undertaken to explore the concept in greater detail. It is only by reconsidering compassion and addressing the implications for contemporary nursing practice that we can truly hope to respond to patients with humanity and kindness, and deliver true high-quality care to all.

BJN

Conflict of interest: none

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- Declare 'compassion' as a core value
 - Reaffirm compassion and articulate it as a professional value
 - Reward rather than punish compassionate caring
 - Reinforce compassionate practice by advocating that staff take time to care and acknowledge the positive impact this has on patients care
 - Hone communication and relationship skills
 - Provide annual staff communication skills training and monitor the value of this via patient satisfaction surveys
 - Provide space for staff to discuss difficult issues
 - Promote opportunities for interactive multidisciplinary discussion about compassionate caring as illustrated by Schwartz Centre Rounds
 - Challenge models of professionalism
 - Strengthen the humanistic approach to care and disregard the notion that professionalism requires detachment from patients
 - Hard wire new behaviours
 - Embed compassionate behaviour into everyday practice
 - Declare compassion as a management and leadership competence
 - Leaders need to role model compassionate behaviour as compassionate leaders result in compassionate organizations
 - Engage health consumers in the change
 - Draw upon patient narratives and service user experiences as a tool for learning and developing practice
- Adapted from Youngson, 2008

Figure 2. Action plan for compassion

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KEY POINTS

- A range of political and professional drivers have re-endorsed the concept of compassion as a core value of nursing
- Compassion requires nurses to feel empathetic to the suffering of others, enter into the realms of this suffering and react in such a way as to demonstrate humanity
- Appropriate recruitment and selection strategies need to be implemented to obtain the most suitable student nurses
- Service users should be used to support recruitment and selection processes, curriculum planning and design and the delivery of teaching and learning strategies
- Nurses need to be supported to enable compassionate care
- Leadership for compassion is essential, quality should be championed from 'ward to board'
- Further original research is essential to explore the concept of compassion in greater detail

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Appendix 2: The Charter for Compassion

*“**The principle of compassion** lies at the heart of all religious, ethical, and spiritual traditions, calling us always to treat all others as we wish to be treated ourselves. Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there, and to honour the inviolable sanctity of every human being, treating everybody, without exception, with absolute justice, equity and respect.*

***It is also necessary** in both public and private life to refrain consistently and empathically from inflicting pain. To act or speak violently out of spite, chauvinism, or self-interest, to impoverish, exploit or deny basic rights to anybody, and to incite hatred by denigrating others- even our enemies- is a denial of our common humanity. We acknowledge that we have failed to live compassionately and that some have even increased the sum of human misery in the name of religion.*

We therefore call upon all men and women:

To restore compassion to the centre of morality and religion

To return to the ancient principle that any interpretation of scripture that breeds violence, hatred or disdain is illegitimate

To ensure that youth are given accurate and respectful information about other traditions, religions and cultures

To encourage a positive appreciation of cultural and religious diversity

To cultivate an informed empathy with the suffering of all human beings- even those regarded as enemies

***We urgently need** to make compassion a clear, luminous and dynamic force in our polarised world. Rooted in a principled determination to transcend selfishness, compassion can break down political, dogmatic, ideological and religious boundaries. Born of our deep interdependence, compassion is essential to human relationships and to a fulfilled humanity. It is the path to enlightenment, and indispensable to the creation of a just economy and a peaceful global community”.*

Taken from: Armstrong (2009)

Appendix 3: The Five Factor Model (FFM) of Human Personality (OCEAN)

Openness-relates to individuals who have are creative, insightful and who have a diverse range of interests. Individuals with low levels of openness are often less creative or adventurous and may find abstract thinking beyond the norm.

Conscientiousness-relates to high levels of thoughtfulness, ability to control impulses and a determination to adhere to goal-directed behaviours. Individuals tend to be organised and possess the desire to ensure attention to detail, compared with individuals who are low in this trait who tend to be disorganised and haphazard in their approach

Extraversion- relates to individuals who are outgoing and energetic in social situations, compared with those who are introverted and who tend to be more reserved.

Agreeableness-includes attributes such as trust, altruism, kindness, affection and a variety of other prosocial behaviours. Individuals who are agreeable tend to be more cooperative compared with individuals who are low in this trait who tend to be competitive and potentially manipulative.

Neuroticism-relates to sadness, moodiness and emotional instability. Individuals who are neurotic tend to experience mood swings, anxiety, moodiness, irritability and sadness. Individuals who have low affinity with this trait tend to be more stable and emotionally resilient.

Adapted from: McCrae and Costa (1987, 1997)

Appendix 4: Ethical Approval

Collette Straughair

This matter is being dealt with by:
Research and Enterprise Office
School of Health, Community & Education Studies

13 July 2012

Dear Collette

School of HCES Research Ethics Panel

Title: Towards an Understanding of Compassion in Nursing: A Grounded Theory Study to Explore the Service User Perspective

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent CRB and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
<http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard>

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely



Professor David Stanley
Chair, School Research Ethics Review Panel

Vice-Chancellor
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle

Appendix 5: Letter of Invitation to Participate in the Research

Invitation to participate in a research study:

“Towards an Understanding of Compassion in Nursing: A Constructivist Grounded Theory Study to Explore Individual Perceptions”

Dear Sir/Madam,

I am a Senior Lecturer in Adult Nursing at Northumbria University and I am currently undertaking a research study to develop an understanding of compassion in nursing. I am particularly interested in finding out what you consider compassion involves, and how this has been demonstrated through your individual experiences of nursing care. I am therefore seeking the views and perceptions of individuals who have experienced nursing care and who wish to share their experiences of compassion as a result of this.

You are cordially invited to consider if you have experiences of compassion in nursing that you may wish to share by participating in this research study. As an experienced member of the university ‘Service User and Carer Group’, you have a wealth of expertise to offer the research study and I would value your contribution. Before you make a decision, you need to understand why the research is being done and what it would involve from you. I have therefore enclosed a detailed information sheet for your attention. This outlines the purpose of the research study and what will be required of you if you agree to take part. Please read this carefully before making any decisions. If you wish, you can contact me to obtain any further information you may require to help you decide. Once you have considered all the information provided and you decide to participate, please complete the enclosed initial consent

form and return it to me in the enclosed stamped, self-addressed envelope. Please be assured that your personal information will be held in the strictest of confidence and that you are free to withdraw from the research at any time without this affecting you in any way.

I would really value your insight into compassion in nursing and would be extremely grateful if you would share your experiences with me, as this is such an important issue. Thank you for taking the time to consider being involved in this research study.

If you feel you are not in a position to contribute to the research study, but know of someone who can, please feel free to pass this information on to them.

Yours faithfully,

Mrs Collette Straughair RN, RM, Dip NSc, BSc, MSc

Principal Investigator / Lead Researcher

Research Study Information Sheet (Version 2.1 dated 5/7/12)

**Towards an Understanding of Compassion in Nursing: A Constructivist
Grounded Theory Study to Explore Individual Perceptions**

What is the purpose of the study?

The aim of this study is to investigate the subject of compassion in nursing. The study aims to generate a deeper understanding of compassion, particularly in relation to what individuals perceive compassion to involve and explore how this has been demonstrated through your experiences of nursing care.

Why have I been asked to take part in this study?

You have been asked to take part in this study because you are a member of the Northumbria University 'Service User and Carer Group', and potentially have experience of nursing care. Members of the group have a wealth of experience in relation to nursing care across a variety of health care environments. Because of this you may have knowledge, expertise and experience of nursing which may be of benefit to the study. The study requires you to share your thoughts, perceptions and insights into compassion in nursing as a direct result of your individual experiences of nursing care. If you feel you wish to share your story, your contribution would be very welcome and highly valued. These experiences can be from positive or negative perspectives.

Do I have to take part in the study?

You do not have to take part in the study, it is entirely up to you to decide if you wish to contribute. If you decide that you have an experience of compassion in nursing that you wish to share and are willing to participate, please complete the

initial consent form and return this to the lead researcher, Collette Straughair. You are free to withdraw from the study at any time, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

What am I being asked to do?

If you agree to participate in the study, in the first instance you will be asked to complete an initial questionnaire. This information will be collated to provide a general overview of people's experiences. As a result, you may be asked to discuss and share your experience of compassion in nursing in an informal interview. Please be aware that not everyone who returns the initial questionnaire will be invited to be interviewed, only a selection of individuals will be chosen. You will be informed if you have been selected by your preferred method of contact. If you are invited to be interviewed, the interview will be conducted by Collette Straughair, at a place and time convenient for you. The interview will be audio recorded and last approximately 45 to 60 minutes. As the study progresses, you may be approached and asked if you would be willing to be re interviewed to elaborate on some elements of your experience. This interview would again last for approximately 45 to 60 minutes. Following this, you may also be asked to contribute to a focus group discussion, which will consist of a small group of service users and will last approximately 60 minutes.

Are there any disadvantages to taking part?

There are no significant disadvantages to you taking part in the research study. The only thing you are being asked to do is to give up some of your time to be interviewed and share your experiences of compassion in nursing. However, you must be aware that this research is not being funded by the university as it is part of a

PhD research study. Therefore, it is not possible to reimburse you for any out of pocket expenses in relation to travelling to the university, although refreshments will be provided.

What are the benefits of taking part?

There may be several benefits to taking part in the study. You will be able to share your insights and perceptions of compassion as a result of your individual experience of nursing care. This may contribute to developing a deeper understanding of compassion and may benefit nurse education in relation to curriculum development and the profession of nursing in general, in terms of what compassion involves and how nursing practice can be developed as a result of this.

Collecting the data

The initial data for this study will be collected via a simple questionnaire. Further data will be collected by individual face to face interview. This will be arranged at your convenience, either at your own home or at the university, according to your preference. At the interview, you will be assigned a unique identifying code which will be attached to your data in place of your personal details. The interview will be recorded using a digital audio recording device. After the interview, the recording will be transcribed into a written format, which you will have the opportunity to review and amend, as required. All data will be anonymised and will not contain your name or any identifying details. All personal details will be kept in the strictest of confidence. If you are asked to contribute to a focus group discussion, data will be collected in a small group and will occur at the university.

Can my relative or carer support me through the interview?

If you wish, you can bring along a relative or carer to support you through the interview process. However, they will be unable to contribute to the interview as their role will be to support you, not to be a part of the research process.

Storage of the interview tapes, transcripts and other papers

All audio and written data will be stored securely and only the lead researcher, Collette Straughair, will have access to this. Electronic data will be stored on the secured university computer network, accessible only by a unique personal user name and password. Paper based data will be stored in a locked cupboard at Northumbria University. Once the study is completed, all data will be destroyed as confidential waste and shredded.

What will happen to the results of the research study?

The results of the study will be shared with the nursing and academic community by a variety of methods. The results will form the basis of a PhD doctoral thesis which is due for completion by October 2016. A variety of articles for publication will also be produced and may be submitted to national and international nursing journals. The results may also be shared with colleagues at local and national conferences. Your personal information will never be disclosed, as only the unique identifying code allocated to you at the interview will be used. However, your words may be published in the form of quotations exactly as you said them during the interview.

Can I find out the results of the research study?

If you wish to be informed about the final results of the study, you can indicate this on the initial consent form. If you indicate this as a preference, at the end of the study you will be invited to attend an informal presentation at the university and also sent a written summary of the key findings.

Who has reviewed this study?

The research has been reviewed by Northumbria University Research Ethics Committee to ensure that it meets ethical requirements.

If I take part can I withdraw from the study at a later date?

You can withdraw from the study at any time, without the need to give a reason. If you wish to withdraw, please contact Collette Straughair directly. If you indicate your intention to withdraw from the study after any interviews have taken place, you will be given the option to allow your story to still be used in the research, or have the data destroyed.

Complaints

If you have concerns about any aspect of this study, please speak to Collette Straughair in the first instance. If you feel your concerns have not been addressed to your satisfaction, you can contact the study supervisor, Dr Steve Tawse.

Information disclosure

Collette Straughair is a Registered Nurse and is governed by the Nursing and Midwifery Council standards for professional conduct. If at any point during the research study, you disclose any information that may raise professional concerns, these will need to be dealt with in accordance with professional guidance. This will be discussed further with you if you decide to participate in the study.

Lead Researcher:

Mrs Collette Straughair, Senior Lecturer

Contact details removed

PhD Supervisor:

Dr Steve Tawse, Academic Lead

Contact details removed

Appendix 7: Initial Consent Form

Initial Consent Form (version 1.3 dated 5/7/12)

**Towards an Understanding of Compassion in Nursing: A Constructivist
Grounded Theory Study to Explore Individual Perceptions**

Participant Identifying Code.....(office use only)

Please initial the appropriate box to indicate your consent

	Yes	No
I confirm that I have read the information leaflet version 2.1 dated 5/7/12 and I understand the purpose of the study	<input type="checkbox"/>	<input type="checkbox"/>
I have had the opportunity to consider the information and ask further questions which have been answered to my satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to complete an initial questionnaire	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw from the study at any time if I change my mind and this will not affect me in any way	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and personal details will be kept confidential and will not appear in any printed documents	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to provide my contact details and be contacted by the lead researcher to participate in the study	<input type="checkbox"/>	<input type="checkbox"/>
I wish to be informed of the final key findings of the study and am happy to be invited to a university presentation and receive a written summary of key findings	<input type="checkbox"/>	<input type="checkbox"/>

I..... [participant]

understand the information presented to me and agree to take part in the research

Signature [Participant] Date

Personal Details

Name:Date of

Birth:.....

Address:.....

.....

.....

.....

.....

Home Telephone:.....

Mobile Telephone:.....

E mail:.....

I am happy to be contacted by (please tick all that apply)

Home Telephone

☐

Mobile Telephone

☐

E Mail

☐

Post

☐

My preferred method of contact is (please specify).....

Please return to:

Collette Straughair

Contact details removed

Appendix 8: Individual Interview Consent Form

Consent Form: Individual Interview (Version 1.3 dated 5/7/12)

Towards an Understanding of Compassion in Nursing: A Constructivist Grounded Theory Study to Explore Individual Perceptions

Participant Identifying Code.....(office use only)

Please initial the appropriate box to indicate your consent

	Yes	No
I confirm that I have read the information leaflet version 2.1 dated 5/7/12 and I understand the purpose of the study	<input type="checkbox"/>	<input type="checkbox"/>
I have had the opportunity to consider the information and ask further questions which have been answered to my satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to be interviewed	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my comments to be audio recorded	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw from the study at any time if I change my mind and this will not affect me in any way	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and personal details will be kept confidential and will not appear in any printed documents	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my comments to be used in the form of quotations in Any reports, papers, conferences, presentations or teaching activities	<input type="checkbox"/>	<input type="checkbox"/>
I wish to be informed of the final key findings of the study and am happy to be invited to a university presentation and receive a written summary of key findings	<input type="checkbox"/>	<input type="checkbox"/>

I..... [participant] understand the information presented to me by Collette Straughair [researcher] and agree to take part in the research

Signature [Participant]

Date

Signature [Researcher]

Date

Appendix 9: Focus Group Consent Form

Consent Form: Focus Group (Version 1.2 dated 5/7/12)

Towards an Understanding of Compassion in Nursing: A Constructivist Grounded Theory Study to Explore Individual Perceptions

Participant Identifying Code.....(office use only)

Please initial the appropriate box to indicate your consent

	<i>Yes</i>	<i>No</i>
I confirm that I have read the information leaflet version 2.1 dated 5/7/12 and I understand the purpose of the study	<input type="checkbox"/>	<input type="checkbox"/>
I have had the opportunity to consider the information and ask further questions which have been answered to my satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
I am willing to participate in a focus group and am happy for my comments to be audio recorded	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw from the study at any time if I change my mind and this will not affect me in any way	<input type="checkbox"/>	<input type="checkbox"/>
I know that my name and personal details will be kept confidential and will not appear in any printed documents	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my comments to be used in the form of quotations in Any reports, papers, conferences, presentations or teaching activities	<input type="checkbox"/>	<input type="checkbox"/>
I wish to be informed of the final key findings of the study and am happy to be invited to a university presentation and receive a written summary of key findings	<input type="checkbox"/>	<input type="checkbox"/>

I..... [participant] understand the information presented to me by Collette Straughair [researcher] and agree to take part in the research

Signature [Participant] Date

Signature [Researcher] Date

Appendix 10: Sampling Questionnaire

Sampling Questionnaire

Towards an Understanding of Compassion in Nursing: A Constructivist Grounded

Theory Study to Explore Individual Perceptions

Name:DOB:.....

Address:.....
.....

Tel:.....E mail:.....

Please answer all the following questions by ticking the appropriate box

1. Have you had an experience of nursing care?

Yes ☐ No ☐

2. In which setting did this nursing care experience occur?

Hospital ☐ Community ☐ Your own home ☐
Other ☐ Please specify.....

3. In which sector did this nursing care experience occur?

NHS ☐ Private ☐ Voluntary/Charitable ☐
Other ☐ Please specify.....

4. Did you experience this nursing care as a result of:

Surgery ☐ Emergency admission to hospital ☐
Routine investigation ☐ Brief intervention ☐
e.g. endoscopy, x ray e.g. bloods, blood pressure check, smear
Ongoing care in your own home ☐ Clinic appointment ☐
e.g. District Nurse e.g. out patients, specialist nurse
Other ☐ Please specify.....

5. How long ago did this nursing care experience occur?

Ongoing ☐ 0-3 mths ☐ 3-6mths ☐
6-12mths ☐ 1-2yr ☐ 2-5yr ☐
5-10yr ☐ Other ☐ Please specify.....

6. *What gender are you?*

Male

☐

Female

☐

7. *How old are you?*

18-35

☐

36-50

☐

51-65

☐

65-80

☐

80+

☐

Other

☐

8. On a scale of 1-10 how would you rate the overall experience of nursing care?

1

2

3

4

5

6

7

8

9

10

Very poor

Excellent

9. On a scale of 1-10 how would you rate the experience of compassion?

1

2

3

4

5

6

7

8

9

10

Very poor

Excellent

I..... [participant] am happy to
be contacted by Collette Straughair [researcher] to participate in an individual interview

Signature [Participant] Date

Return to: Collette Straughair, Contact details removed

Appendix 11: Sample Population Matrix

	1 a	1 b	2 a	2 b	2 c	2 d	3 a	3 b	3 c	3 d	4 a	4 b	4 c	4 d	4 e	4 f	4 g	5 a	5 b	5 c	5 d	5 e	5 f	5 g	5 h	6 a	6 b	7 a	7 b	7 c	7 d	7 e	7 f	8	9	
P1	*		*	*	*		*	*	*		*	*			*	*	*							*			*					*		8	8	
P2	*		*				*				*									*						*				*				9	9	
P3	*		*	*	*		*	*	*		*	*	*	*	*	*		*									*				*				8	8
P4	*		*	*	*		*		*		*		*	*		*							*				*				*			9	10	
P5	*		*			*	*				*	*	*	*		*									*		*			*				4	5	
P6	*		*				*						*			*						*				*				*				9	7	
P7	*		*				*									*	*		*							*			*					8	4	
P8	*		*			*	*	*				*					*	*									*				*			2	2	
P9	*		*	*			*					*	*			*		*									*				*			1	1	
P10	*		*	*	*		*				*	*	*	*		*			*							*					*			7	6	
P11	*		*			*	*	*			*					*	*							*		*				*				3	3	

P12	*		*				*				*											*				*				*				9	9
P13	*		*				*				*												*			*					*			7	6
P14	*		*				*				*							*								*				*				7	6

P15	*		*	*	*		*	*				*					*	*								*			*					6	3
P16	*		*				*				*		*	*						*						*				*				6	5

Each row represents a participant and the information collated from their sampling questionnaire

Participants 1-11 were selected for interview, Participants 12-14 were not selected for interview, Participants 15-16 were selected for interview but declined at this point

Matrix Key:

Q1	Have you had an experience of nursing care?	Q5	How long ago did this experience occur?
1a	Yes	5a	Ongoing
1b	No	5b	0-3 months
Q2	In which setting did this experience occur?	5c	3-6 months
2a	Hospital	5d	6-12 months
2b	Community	5e	1-2 years
2c	Own home	5f	2-5 years
2d	Other	5g	5-10 years
Q3	In which care sector did this experience occur?	5h	Other
3a	NHS	Q6	What gender are you?
3b	Private	6a	Male
3c	Voluntary or charitable	6b	Female
3d	Other	Q7	What age range are you in?
Q4	Did you experience this nursing care as a result of:	7a	18-35
4a	Surgery	7b	36-50
4b	Emergency admission	7c	51-65
4c	Routine investigation	7d	65-80
4d	Brief intervention	7e	80 +
4e	Ongoing care	7f	Other
4f	Clinic appointment	Q8	On a scale of 1-10 how would you rate your overall experience of nursing care?
4g	Other	Q9	On a scale of 1-10 how would you rate your experience of compassion?

Appendix 12: Theoretical Sampling Strategy

Sequence of Participant Selection for Interviews and Focus Group Discussion

Sequence of Participants	Rationale for Selection
Individual Interviews: December 2012-July 2014	
Participant 1: December 2012	This female participant was the only one who was in the 80+ category. Participants in this age group are considered to be hard to sample groups and it is noted in the literature that it is often notoriously difficult to engage them in research. For this reason, I felt it was important to include her. She had identified on the sampling questionnaire that she had a wide range of nursing care experiences to discuss, which had occurred in a variety of NHS and private care settings. Although she indicated that her experiences had occurred 5-10 years previously, I was keen to gain her perceptions. I assumed that her diverse experiences would lead to collecting rich initial data which would serve as the foundation for subsequent data collection and this undoubtedly proved to be the case. In grounded theory research, the initial participant is considered to be the ‘gatekeeper’ and is key to determining further sampling and data collection. As I had previously met this participant in my academic role, I was aware that she was very articulate and had an engaging approach to sharing her narratives and I felt this would be beneficial to the foundation of my research. I also wanted to commence the research with participants who had identified that their experiences were positive and she had rated her experience of compassion as 8.
Participant 2: January 2013	This male participant had encountered a very recent experience of nursing care which had occurred in the 0-3 month period prior to the interview. This emergency admission was the only episode he identified on his initial questionnaire, so he clearly had significantly less experiences of nursing care than Participant 1. However, he had rated his experience as 9 and I was interested in exploring the reasons for this further. I also wanted to continue collecting data from participants who highlighted positive experiences of compassion at this point. I assumed that I would be able to explore his perceptions of his very recent experience and make comparisons with Participant 1’s more distant experiences, thus potentially enhancing the very early emerging codes and tentative categories. This proved to be the case as remarkably similar concepts emerging from participant 1 were evident in his data.
Participant 3: March 2013	This female participant had identified a wide range of nursing care experiences, some of which were ongoing at the point of data collection. Following early analysis of the data from participants 1 and 2, I was developing an emerging sense of what compassion represented for participants in terms of nurses demonstrating a range of specific personal qualities and professional skills which I had assimilated into tentative categories. A strong sense that this

	<p>was influenced by inherent biological/genetic factors was also evident from the analysis so far. Participant 2 had also introduced additional concepts relating to the impact of resources in relation to care contexts and the potential impact this could have on the nurse's capacity for compassion. As this participant was experiencing ongoing nursing care, I wanted to explore her perceptions of this within a current context and use the grounded theory constant comparative analytical method to compare her data with the existing data. I assumed that this would strengthen the emergent codes and tentative categories identified from the data thus far. Additionally, I wanted to continue data collection with participants who had identified positive experiences of compassion and this participant had rated compassion as 8. The emergent codes identified so far were further supported by this participant's data and the issue of resources clarified further, in addition to providing additional emerging codes related to lack of time, the impact of systems and processes such as technology and the notion of being treated as a person/human.</p>
Participant 4: July 2013	<p>This female participant was selected next as one further individual with extremely positive experiences of compassion in a wide variety of care contexts, which she had rated as 10. These experiences had occurred within the past 2-5 years. I had gained a wide range of rich and detailed data thus far which was supporting my early analysis related to personal qualities and professional skills representative of compassion. I had also uncovered a series of potential factors which could enable or inhibit compassion and an emerging sense of the importance of treating people as human beings from participant 3's data. I therefore wanted a further opportunity to collect data which may have the potential to support these emerging findings further, before I moved on to interview participants with less positive experiences. As this participant had experience across a wide range of care contexts I assumed she would be able to contribute to provide this.</p>
Participant 5: September 2013	<p>This female participant had rated her experience of compassion as 5, far less positively than the previous participants interviewed so far. Her experiences had occurred in a wide range of care contexts but they had occurred in excess of 10 years previously. During the interview I learned that this participant was a retired Registered Nurse herself and her data gave further insight into issues such as genetic/biological influences on compassion and the value of nurturing socialisation processes such as education, role modelling and leadership. Her perceptions had clearly been influenced somewhat by her own professional experiences as a nurse and this provided an alternative view of compassion. However, there was a strong accord with the data collected thus far in terms of also highlighting the importance of personal qualities, professional skills/behaviours and extrinsic factors related to nurturing strategies and systems and processes.</p>
Participant 6:	<p>This female participant had been recommended by participant 1 at the initial stages of my data collection as a potentially invaluable</p>

October 2013	contributor to the research due to her previous role as a Registered Nurse. Following the previous interview with another Registered Nurse I wanted to explore compassion further from this specific perspective and gain her personal insights into compassion in nursing as both a care giver and care recipient. Her perceptions were invaluable to strengthening the emergent findings arising from the data so far and served to confirm my emerging constructions of the properties and categories related to genetic influences, personal qualities, professional skills, education, role modelling, leadership, extrinsic factors related to systems and processes impacting compassion in nursing and the importance of focusing on the person as a human being.
Participant 7: December 2013	This female participant had encountered an experience within the previous 3 months which she had rated as 4 on the compassion scale of 1-10. This was the first interview conducted where the participant had rated the experience at a value less than 5. I selected a participant with a recent negative experience at this stage as I now wanted to use a 'flip-flop' technique to advance my analysis by beginning to compare negative experiences with positive experiences. This technique aims to establish if similar categories and properties emerge from the data, despite negative or positive perceptions of the experiences encountered. This proved to be the case and the emergent tentative categories developed thus far were strengthened further with additional participant data that enhanced my analysis and served to facilitate an early sense of achieving progress towards theoretical saturation. In particular, the data seemed to be strongly influenced by the importance of treating the person as a human being as a result of this participant's perceptions of feeling objectified throughout her experiences.
Participant 8: February 2014	This female participant was sampled next as she was experiencing ongoing nursing care in both NHS and private care contexts, which she rated as the least compassionate of participants sampled so far, at a level of 2. Her data served to further enhance my developing sense of reaching a degree of theoretical saturation. It also provided further emerging comparative codes from a negative perspective that were commensurate with the codes arising from the previous data which were from a positive perspective. No new codes really emerged from this data, however the codes identified thus far were supported further by additional examples of nursing care experiences to support the evolving grounded theory.
Participant 9: April 2014	This female participant had rated her experience of compassion at the lowest level of all the sample population who completed and returned the initial sampling questionnaire. I deliberately left this participant to this stage of data collection in order to enable me to analyse her data within the emergent properties and categories which had arisen from ongoing data analysis thus far. The rationale for this was to provide further credence to the emergent developing grounded theory. Despite the highly negative angle of this data, it was clear that there was strong accordance with the developing theory. The concepts of personal qualities and professional skills

	<p>to facilitate a person focused and human approach to enable compassion were evident in her data. The notion of socialisation via educational and role modelling strategies was further supported. However, this participant expanded this code to suggest that socialisation in general society was also an important precursor to compassion. At this stage of data collection, I was beginning to feel a level of confidence that the emerging theory I was constructing from the data was reflective of participant experiences and was advancing towards achieving theoretical saturation.</p>
<p>Participant 10: June 2014</p>	<p>This male participant was selected as I wanted to seek further views from a male perspective and make comparisons with the previous male participant's data. At this stage of data collection, I also felt unsure if I had adequate data to be confident that theoretical saturation had been achieved, despite identifying that no new codes or categories were emerging from data analysis. Discussion with my supervision team led me to conclude that I would conduct 2 further interviews, one with a participant who had rated the perceived level of compassion above 5 and one with a participant who had rated the level of compassion below 5. It was assumed that this approach would afford the opportunity to further explore both a positive and a negative perception to establish if the same codes previously identified were still emerging and also to potentially elaborate category properties. The aim was to strengthen the theory constructed from participant perceptions thus far and afford additional confidence that theoretical saturation was approaching. This male had experienced a very recent encounter of nursing which he had rated at a level of compassion of 6. No new codes, categories or properties emerged from his data, however a range of additional evidence was provided to support the emergent theory. However, I was aware that there was a strong underlying theme in this data relating to personhood/being treated as a human being.</p>
<p>Participant 11: July 2014</p>	<p>This female participant was sampled from the matrix due to her experience in both NHS and private care contexts. Her experiences of compassion had been rated at a level of 3, so were indicative of a negative experience. This final individual interview gave me the confidence that theoretical saturation had almost been achieved in the research as no new properties or categories emerged. However, the data collected proved extremely valuable in further supporting the emergent grounded theory.</p>

Focus Group: December 2014	
Participant 11	Selected for her negative experience of compassion which was rated as 3. Analysis of her individual interview suggested that she may be able to offer further saturation of the categories related to personal qualities, professional skills and socialisation/nurturing strategies which were noted to be strong themes in her data.
Participant 2	Selected for his positive experience of compassion which was rated as 9 and also because this was one of only two male participants involved in the research. Data analysis of the interview identified a strong focus on care environments in relation to resources and workloads.
Participant 3	Selected for her positive experience rated at a level of 8. This participant's data uncovered a strong focus on contextual/structural factors, specifically in relation to technology, documentation and time. Her data also revealed a strong emphasis on the importance of personhood.
Participant 1	Selected for her wide range of nursing care experiences and because she was the initial 'gatekeeper' to sampling and data collection. Unfortunately, due to ongoing ill health she was unable to participate and withdrew from the research at the last minute. However, she consented for the data she had shared to remain in the research.
Participant 8	Selected due to negative experiences which were rated at a level of 2. Unfortunately, she failed to attend on the day so was unable to contribute to the focus group.
Participant 6	Selected as she was a retired Registered Nurse to provide an alternative perspective from both a care giver and care recipient point of view. Unfortunately, due to ongoing ill health she was unable to offer any further contribution and withdrew from the research at this point. However, she consented to the data she had previously shared to remain in the research.
Additional Individual Interviews	
Participant 7: July 2015	Selected to further explore her perceptions of feeling dehumanised which she had identified in her individual interview. The aim was to elaborate on this previous data and saturate the emerging core category further.
Participant 10: July 2015	Selected as previous data suggested a strong underlying theme relating to personhood/being treated as a human being. It was envisaged that this participant would be able to contribute to saturation of the core category further and offer an alternative perspective from a male point of view.
Participant 3: August 2015	Selected as her previous data had strongly indicated the importance of being treated as a human being. It was assumed that her experiences and insight would offer further elaboration and saturation of the core category.

Appendix 13: Interview Topic Guide

Primary question:

Can you tell me what you think compassion involves and give examples of how your experiences of nursing care have contributed to your understanding of this?

Additional questions addressing research objectives to be asked as required:

- How would you describe or define compassion? What does compassion mean to you? What does compassion involve?
- Can you tell me how the Registered Nurses who were caring for you demonstrated/failed to demonstrate compassion during your experiences?
- What were the specific things that Registered Nurses did to make you feel they were being compassionate/uncompassionate?
- Can you tell me about the environments where your nursing care experiences occurred?
- Is there anything else you want to add about compassion or your experiences of nursing care?

Examples of refinements:

- In terms of compassion, can you tell me what kind of things really mattered to you?
- Can you tell me about any differences you noticed in the contexts where you experienced care?
- Can you tell me what your expectations were of the Registered Nurses who were caring for you?
- Can you tell me about the ways in which Registered Nurses have interacted with you?
- Can you tell me if, and how, your experiences affected or impacted you?
- Can you tell me about any factors you think might have had a positive/negative impact on compassion?
- Can you tell me what you think Registered Nurses could have done differently?
- Can you tell me about the importance of being treated as a person/human? Can you clarify what this means for you personally? Can you elaborate on your experiences of this?

Appendix 14: Focus Group Discussion Guide

Discussion Point 1: Personal Qualities/Attributes

The following qualities have been identified from your interviews as important to your individual perceptions of compassion. Following data analysis, they have been divided into 2 groups. Feel free to write on the sheets provided.

1. What other qualities do you feel are essential to compassion? Why are they important to you?
2. Which qualities would you prioritise and why?
3. If you were asked to use a term or phrase to describe the collective qualities in group 1 and group 2 what would that be?
4. What examples can you provide of how these qualities have been demonstrated through your experiences of nursing care?

Group 1: Effective communicator, Intuitive, Positive body language, Active Listener, Connected, Thoughtful, Considerate, Understanding, Attentive, Observant, Friendly, Patient, Respectful, Positive regard for others, Interested, Able to develop relationships, Uses appropriate language, Approachable, Accessible, Uses touch, Kind, Sensitive, Reassuring, Caring, Helpful, Honest, Enthusiastic, Positive attitude, Encouraging, Pleasant, Concerned, Flexible, Accommodating

Group 2: Person Focused, Empowerment, Collaborative, Inclusive, Negotiation, Non-judgemental, Equality, Holistic, Continuity, Knowing the person, Individualised, Skilled, Knowledgeable, Shifting the balance of power

Discussion point 2: Enablers and Inhibitors

The following quotes overleaf have been taken from some of your interviews.

1. What does this collection of quotes mean or signify to you?
2. What do you think the people who have shared these quotes are trying to say/convey?
3. Do you have any other examples to share that might reflect similar experiences?

“there was one of them said “that toe looks uncomfortable” and she cut my toe nail for me. Now, I didn’t ask her but I thought it was lovely... the little things, they make such an enormous difference”

“he just made a special effort to be daft, and you know, pinch my teddy that I had on the bed and, you know, take it round the wardand he used to sort of dance with it and it cheered me up. You know, it’s just silly things.”

“I don’t go in expecting, I just expect to be looked after and made better and come out and whatever you put up with is immaterial.”

“it’s really getting into somebody’s psyche. It’s noticing that they’re upset and taking their time to think: what can I do?”

“I think the majority of them go in because they are a caring person to begin with....it’s sort of inbred in you really, it’s such a strange thing....it’s as though you have got like a stamp on your head”

Discussion Point 3: Enablers and Inhibitors

Analysis of your interviews suggests that there are a range of factors which can have an impact on your perceptions of compassion.

The experiences you shared identify things that can impact positively and things which can impact negatively.

Some examples of this can be seen in the following quotes overleaf.

1. What factors have contributed to a positive experience of compassion for you?
2. What factors have contributed to a negative experience of compassion for you?
3. What kind of impact does a positive or negative experience have on your perception of compassion?
4. What other factors do you think can influence compassion?

“I think the emphasis is more on machinery. You know they might know how to programme your dialysis machine but because of other work pressures, they haven’t got the time to sit on the end of your bed now and notice you’re upset like they used to”

“too much paperwork and standards...targets, you know, I think there’s too much emphasis on that”

“there’s not enough people on the battlefield... there always seems to be a shortage of staff on the ward and it’s not the nurses’ fault. I think their workload is incredible”

“It’s a different world altogether, being in Intensive Care and then going on to the ward. I mean the nurses on the ward were great. I mean, bless them; they work hard. But it wasn’t the same as having like, the one-on-one basically for 24 hours.”

“you feel more like a statistic. That they just want to fix you up and get you out....they haven’t got time to sit and talk to you for five minutes. I think that’s really sad”

Discussion Point 4: Enablers and Inhibitors

Consider the quotes.

1. What do these quotations mean to you? What do they signify? What is the person being interviewed saying?
2. What other examples of similar experiences or perceptions related to these quotes can you share?

“I’m a firm believer that you should treat others how you would want to be treated yourself...behaviour breeds behaviour you know...you can’t pour all your compassion endlessly down a well, you’ve got to have either job satisfaction or something to make it worthwhile”

“I think a lot will depend on the sister in charge of the ward, on what they’re like and if they pick up on how their staff act, you know.”

“a sister in a gynae ward and... she ran the ward like a military operation and you weren’t allowed to speak to patients.... you couldn’t fault the care, the clinical care.....of course, when she wasn’t on duty, we would talk to the patients”

“you are involved much more in your treatment you are treated better I think, more sensitively.....its presumably been, to do with the education.”

“it’s all to do with..... the training they’re being given”

Discussion Point 5: A sense of personhood

Consider the following quotes.

1. What do they signify to you? What key message are they conveying to you?
2. Can you provide any other examples of this from your own experiences of nursing?

“you can’t know everybody’s likes and dislikes but knowing somebody definitely hates something and you do remember that, the patient feels a little bit special”

“I think there’s too much emphasis on that, rather than you know, seeing people as humans”

“you just feel as if they’re less interested in you as a person; you feel more like a statistic”

“Compassion is an all- enveloping and complete understanding of the patient, knowing the person”

“it’s about treating people like human beings”

“she doesn’t see an object in front of her she sees a human being, a person”

Discussion Point 6: Further information

1. What other thoughts do you have to share about your experiences of compassion in nursing?
2. Is there anything else that you would like to add?

Appendix 15: Gantt Chart

Activity:Y1	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
Project Approval												
Ethical Approval												
Initial Literature review												
Contact Target Sample												
Activity:Y2	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Annual Review												
Contact Target Sample												
Assimilate Sample Matrix												
Sample Initial Participant												
Initial Data Collection												
Initial Data Analysis												
Theoretical Sampling												
Data Analysis												

Activity:Y3	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Annual Review												
Theoretical sampling												
Data Analysis												
Activity:Y4	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Annual review												
Recruit focus Group												
Data Collection												
Data Analysis												
Additional Data Collection												
Additional Data Analysis												
Focused Literature Review												
Writing Up Thesis												

Activity:Y5	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Annual review												
Focused Literature Review												
Writing up Thesis												
Submission												

Appendix 16: Example of Data Analysis Using Data Extract

Initial Coding:

Participant Data	Initial Codes
<p>“to me it means, well it’s kindness, it’s often to do with body language. I mean to diverge very slightly, when I was a receptionist, you could see all styles of receptionists and people coming into the surgery, to a slighter degree possibly, they were just like people going into a hospital situation. They weren’t well, they wouldn’t be there if they were, they were concerned, they were anxious, sometimes they were embarrassed and the first initial contact they got was from the reception desk. I felt you should be kind, put them at their ease, to be, now what’s the word.... for them to be open to them and try and make them feel that they could, to find out what was the matter...to try and sort of give them a relaxed relationship. And, there again you see, it’s partly to do with your personality. There’s all sorts of things I’m not good at, I don’t drive and I’m not very sort of mechanically minded, but I’m quite good with people and I like people, I’m interested in people, and you know the soft answer that turneth away wrath is always my approach. So, that was a good</p>	<p>Being kind</p> <p>Using positive body language</p> <p>Recognising differing personalities</p> <p>Using professional skills/interactions</p> <p>Initial impressions</p> <p>Being kind</p> <p>Offering reassurance</p> <p>Using effective communication</p> <p>Listening to people</p> <p>Being attentive</p> <p>Developing professional relationships</p> <p>Recognising differing personalities</p> <p>Focusing on the person</p> <p>Taking an interest</p> <p>Assuming a positive approach</p>

<p>experience and I think it was appreciated. Similarly in hospital, and the same pre requisites there you know, where you're there for something, you're a bit scared, you don't know what they might find and you want someone...and some nurses are so excellent at it, you know they're not sort of all over you but they're kind, they're gentle, they're sympathetic and they don't hustle you and bustle you around....it's the whole approach, and some people have this approach and others don't"</p>	<p>Positive perceptions</p> <p>Being observant Being attentive Recognising differing personalities</p> <p>Being kind Using a gentle approach Using empathy Being patient</p> <p>Assuming a positive approach</p>
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Focused Coding:

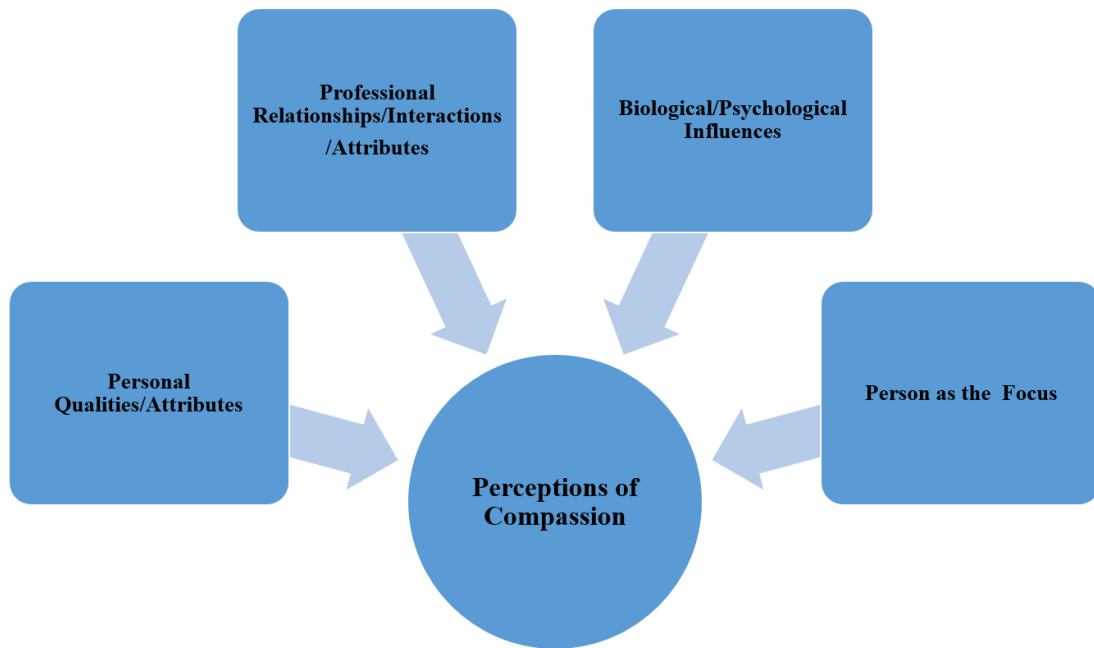
Initial Code	Focused Code/Tentative Category
<p>Being kind</p> <p>Using positive body language</p> <p>Offering reassurance</p> <p>Being attentive</p> <p>Taking an interest</p> <p>Assuming a positive approach</p> <p>Being observant</p> <p>Being attentive</p> <p>Using a gentle approach</p> <p>Using empathy</p> <p>Being patient</p>	<p>Personal Qualities/Attributes</p>
<p>Using professional skills/interactions</p> <p>Using effective communication</p> <p>Listening to people</p> <p>Developing professional relationships</p> <p>Initial impressions</p>	<p>Professional Relationships/Interactions/Attributes</p>

Focusing on the person	Person as the Focus
Positive perceptions	
Recognising differing personalities	Biological/Psychological Influences

Theoretical Memo:

This participant clearly identifies compassion to be a complex phenomenon, involving a wide range of factors. There seems to be a strong focus on the individual attributes of the nurse, which the participant perceives to be compassionate, and how these are used to facilitate positive engagement and interaction. The participant has drawn upon her own employment experiences and compared the skills she used as a medical receptionist to more generic nursing care contexts. Her personal experiences and how she acted towards people she came into contact with has evidently contributed to her developing her own individual perception of what constitutes compassion in nursing. This seems to be a social construction of her perceptions, developed through her everyday experiences of social life, which she has translated to her understanding of compassion in nursing. A range of personal qualities seemingly represent what compassion means to her, attributes such as kindness, patience and empathy. She also identifies that communication, listening and assuming a positive approach are important. She does, however, identify individual differences in people and this suggests that there is a notion of intrinsic or inherent personality, which can influence the individual and their ensuing approach to people. In fact, she provided an example to illustrate this which suggested that compassion comes from within. Professional qualities seem to have a role to play here too, in relation to being able to draw upon these to interact in such a way as to manage fears and anxieties and help the individual perceive a positive experience of compassion. The potential categories emerging seem to relate to biological/genetic influences, which can possibly impact on personal qualities/attributes and professional relationships/interactions/attributes, which lead to developing the participant's perceptions of compassion. There seems to be a sense of importance relating to the impact on the individual and the need to focus on the person too. I need to follow up these leads in my next interview to see if I am really seeing the bigger picture and interpreting this appropriately.

Theoretical Diagram:



Advanced Coding:

Initial Code	Focused Code/Tentative Category	Property	Final Category
Being kind Using positive body language Offering reassurance Being attentive Taking an interest Assuming a positive approach Being observant Being attentive	Personal Qualities/Attributes	Personal Attributes	Attributes for Compassion

Using a gentle approach Using empathy Being patient			
Using professional skills/interactions Using effective communication Listening to people Developing professional relationships Initial impressions	Professional Relationships/ Interactions/ Attributes	Professional Attributes	Attributes for Compassion
Focusing on the person Positive perceptions	Person as the Focus	N/A	Humanising for Compassion- Core Category
Recognising differing personalities	Biological/ Psychological Influences	Intrinsic Disposition for Compassion	Self Propensity for Compassion

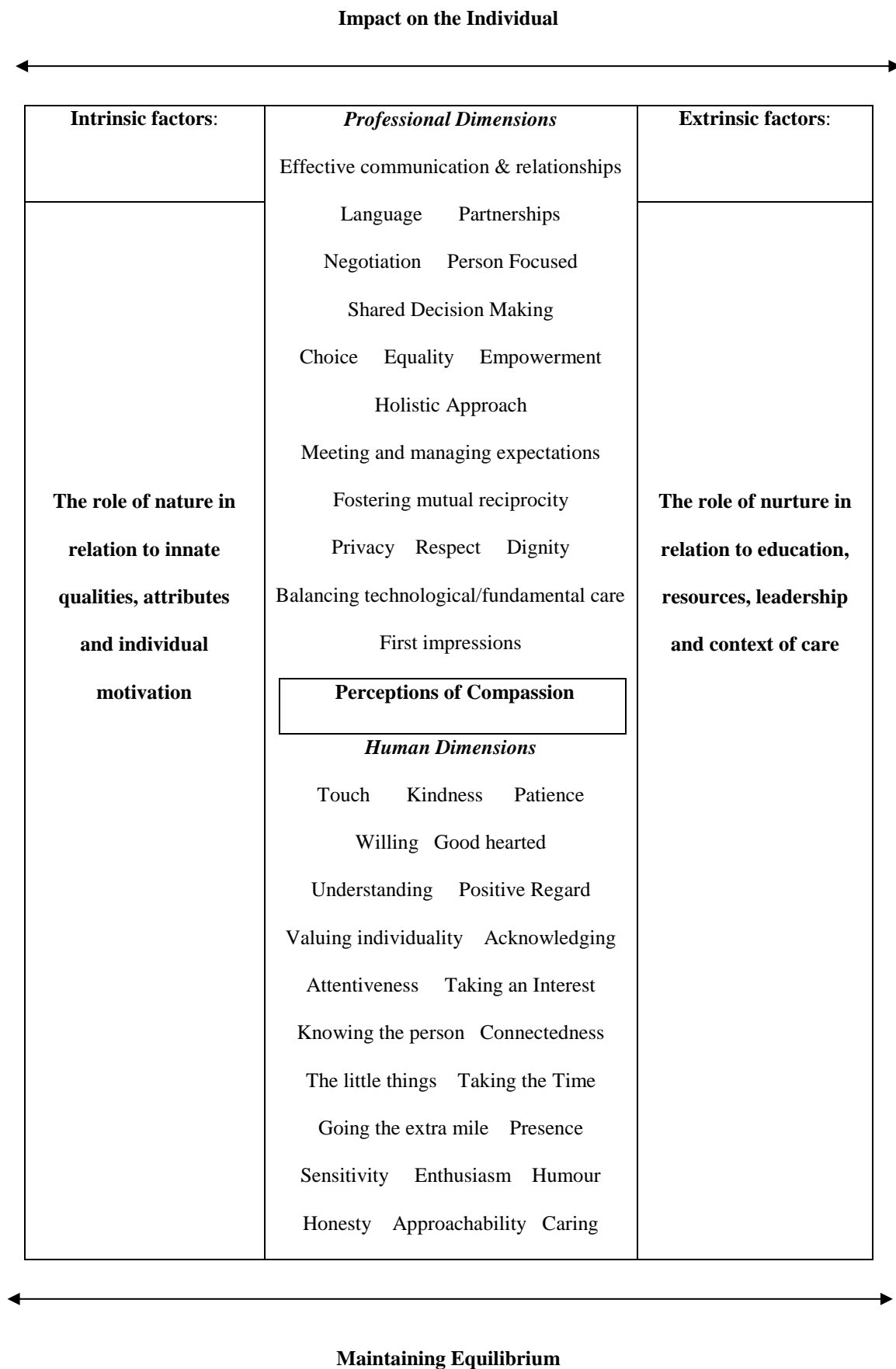
Appendix 17: Theoretical Sorting Analytical Iterations

July 2013

Theoretical Memo:

Initial analysis of the data suggests that compassion is a complex and multi-dimensional concept which seems to have individual significance to participants and this is influenced by a variety of intrinsic and extrinsic factors. The data seems to suggest that there are a range of professional and human dimensions associated with participant's perceiving compassion and these are influenced by the innate qualities and attributes of individual personality. However, there seems to also be a recognition that extrinsic factors can have an impact on compassion, factors which seem to be influenced by a nurturing process involving education, leadership and the care environment. At this stage there are many conceptual codes emerging and I am unsure how they fit together, but what I do think at this point is that there is something important arising from nature – nurture/ intrinsic –extrinsic factors. Clearly the experiences of the participant data analysed thus far indicates a range of positive and negative perceptions and the impact this has had on the individual experience and perception. Perhaps there is an element of balance or equilibrium required to juggle these intrinsic and extrinsic factors to enable positive perceptions of compassion.

Theoretical Diagram:



October 2013

Theoretical Memo:

It is becoming clear that participants perceive that compassion is linked to the qualities and attributes of nurses and is demonstrated by acts of humanity and kindness which attend to the “little things” and often go above and beyond the call of duty. Kindness, patience, attentiveness, communication, inter personal relationships, partnership and respect for personhood and individuality are some of the dimensions identified by service users as vital components and this seems to indicate tentative categories of human and professional elements of compassion. There is also a strong sense that nature and nurture have a role to play in relation to innate personality and the influences of education, leadership, availability of resources and the care environment. I will use this as a tentative category for the moment but I am unsure of the validity of this label, but it can serve as a guide for now.

1. Human Elements of Compassion

Qualities and attributes of the compassionate nurse
Making the effort with the little things to go the extra mile
Relationships and first impressions

2. Professional Elements of Compassion

Valuing individuality and personhood
Partnership, choice and empowerment
Appropriate use of language and discourse
Managing patient expectations to facilitate mutual reciprocity

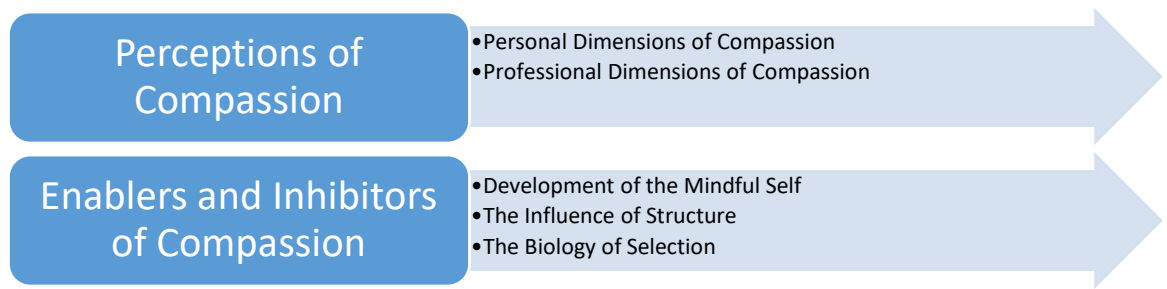
3. The Influence of Nature and the Impact of Nurture

Innate personality traits
The impact of education, leadership and resources
The context of care delivery

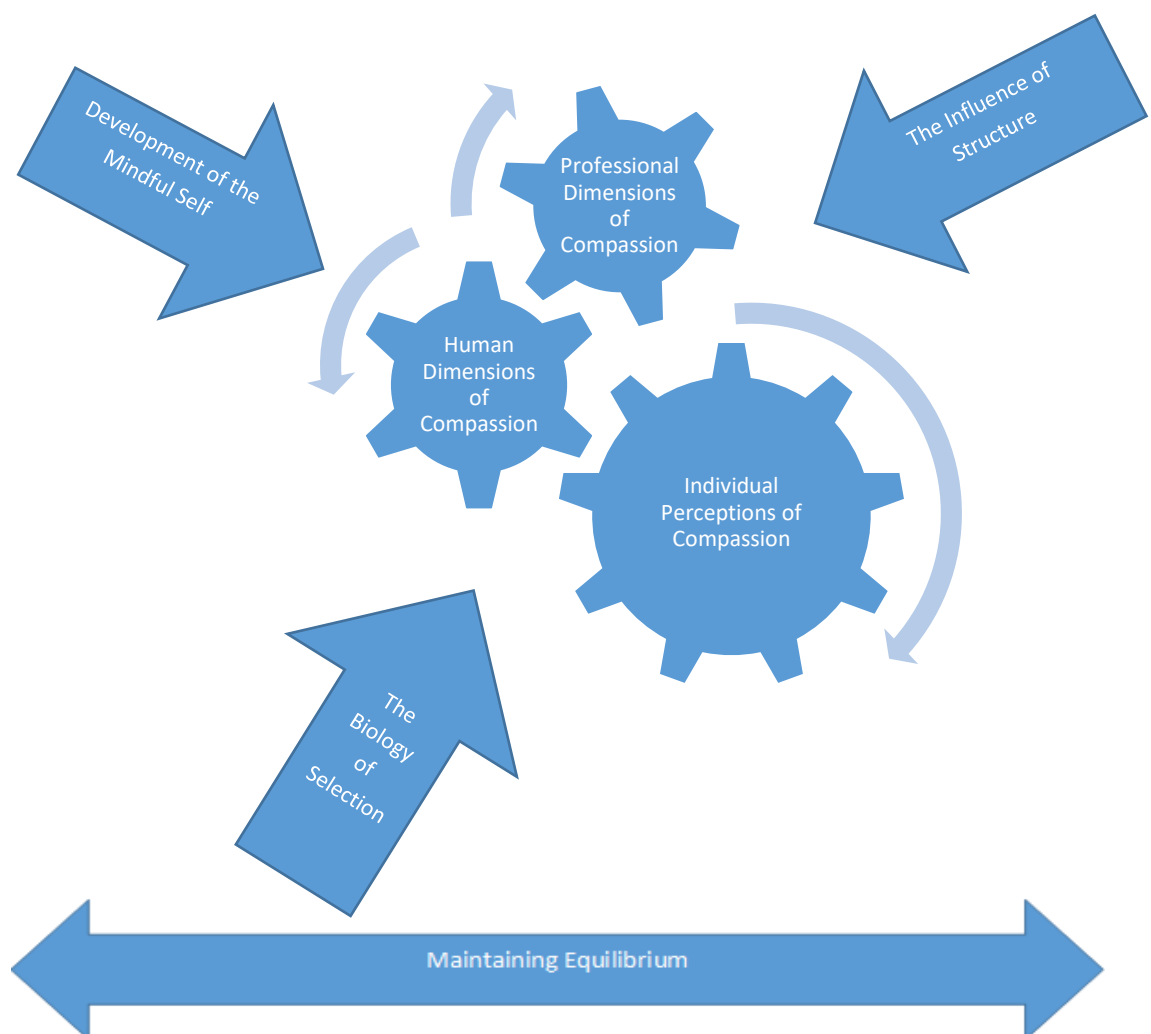
February 2014

Theoretical Memo:

As analysis progresses, the categories relating to human and professional elements of compassion continue to come through the participant data strongly. However, rather than two separate categories, I am starting to think that they are linked together and are at the core of participant perceptions of what compassion represents. For this reason, I will relabel the category as perceptions of compassion for now and highlight personal and professional dimensions as the properties of this. The other emerging category seems to relate to extrinsic and intrinsic factors which enable or inhibit compassion. The notion of the nature-nurture issue is still evident but I feel this is an outdated term and already an extant debate that I am not sure is appropriate to the originality of my analysis. The issues of innate personality and self, influenced by biology and genetics continue to emerge, as does a strong sense of the impact of structure as in the context of the environment of care, workload, resources and leadership issues. So, what I think the data is revealing is that participants perceive compassion as a result of their experience of personal and professional qualities, attributes and behaviours but this is influenced by factors related to inherent personality, the individual self and the impact of external structural issues in terms of workload etcetera. It seems that a balance between these factors is essential to facilitate positive participant perceptions of compassion. The notion of being treated as a human being seems to increasingly be a concept of immense significance, although I am unsure how this fits with the overall emergent theory at this stage.



Theoretical Diagram:



August 2014

Theoretical Memo:

The data is uncovering an extremely complex picture of what compassion represents to participants and a wide range of factors which can have an impact on the nurse's capacity to demonstrate compassion. I feel that the grounded theory is evolving to represent a fuller understanding of what compassion in nursing entails to the participants in my research and this is far more detailed than I ever anticipated.

There is a clear insight into participant constructs of compassion, in terms of the elements that contribute to representing what compassion means for participants as a result of their experiences of nursing care, but also as a result of their personal experiences and interactions through everyday social life. The issue of factors which enable or inhibit compassion as a result of extrinsic and intrinsic influences involving the self, others and the structural context is a major category contributing to developing an understanding of compassion. It is clear that participants perceive these two categories to contribute to their sense of being treated as a human being/personhood and this has a significant impact on their overall perceptions of compassion. At this stage of analysis, I have assimilated the emerging focused codes into 3 overarching categories which are now forming a coherent and plausible grounded theory.

Category 1: Constructs of Compassion (the elements that contribute to the meaning of compassion)

- a. Personal dimensions of compassion
- b. Professional dimensions of compassion

Category 2: Enablers and Inhibitors of Compassion (the factors that contribute to the individual being able to demonstrate compassion)

- a. The role of self:

Developing the mindful self

Intrinsic characteristics

Going the extra mile

b. The role of others:

Reciprocity

Power influences (top down approach)

Organisational leadership

Education and role modelling

c. The Role of structure:

Context and culture of care

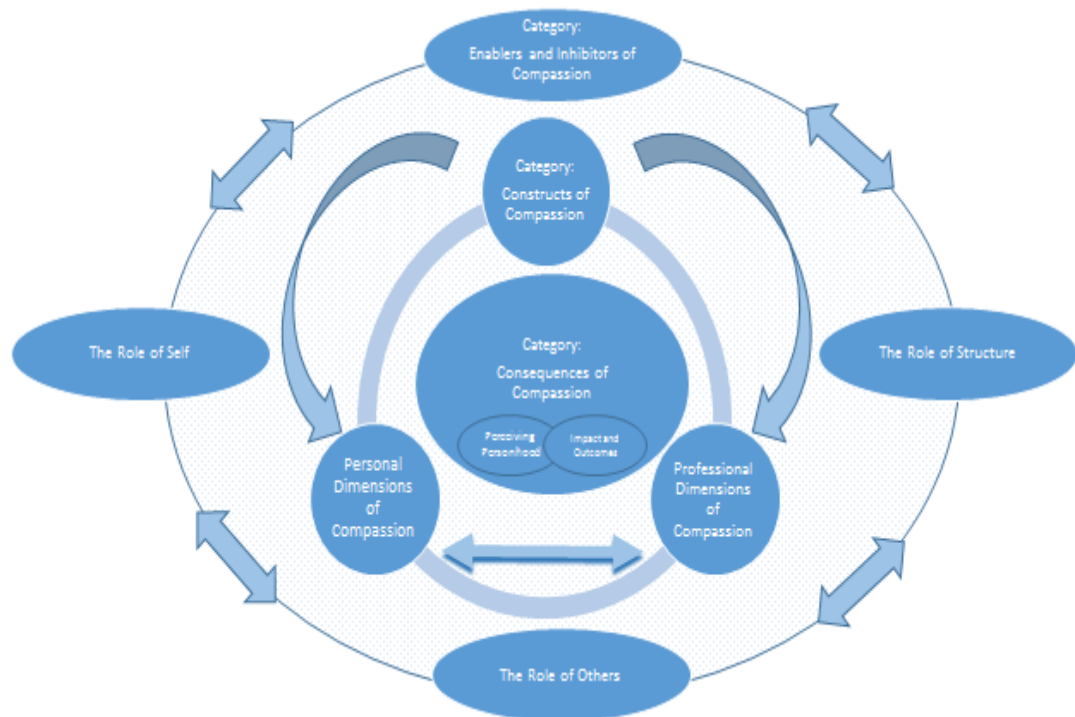
Systems and processes (targets, resources, workload/time, technology)

Category 3: Consequences of Compassion

a. Perceiving personhood

b. Impact and outcomes

Theoretical Diagram:



February 2015

Theoretical Memo:

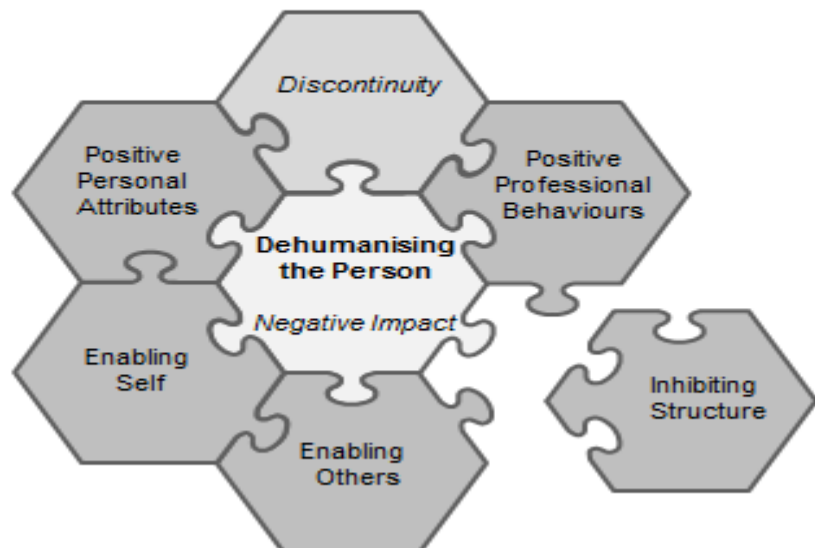
The focus group transcript has really helped me to develop a greater insight into what the overall data is revealing. Analysing this prompted me to go back to earlier interview transcripts again to ground my initial analysis to understand what exactly the participants were trying to tell me. It is now even clearer in my mind that the demonstration of positive personal attributes and professional behaviours is what participants perceive represents compassion to them. Factors in the guise of the individual self, the role of others and the influence of structure and context of care are significant in enabling nurses to demonstrate these personal attributes and professional behaviours. When these are all balanced in a state of continuity/equilibrium, participants perceive they are humanised and they report positive experiences of compassion. However, in contrast to this when there is discontinuity/disequilibrium and all the pieces of the puzzle are not in place, participants can feel dehumanised and experience a negative perception of compassion. An example of this is illustrated in the data where participants report that in circumstances where there are low staffing levels and high workloads, the nurse's capacity for compassion is inhibited. I have developed a matrix to represent this but I am still unsure if the terms I have used are accurate and clear enough for others to comprehend my construction of the theory. I need to perhaps be more reflexive about this and return to Charmaz's text to further explore her stance on implementing the analytical methods to ensure that my grounded theory is robust. I think I may need to perhaps draw on some of Clarke's situational mapping to advance my analysis to a higher and more abstract position.

Theoretical Diagram:

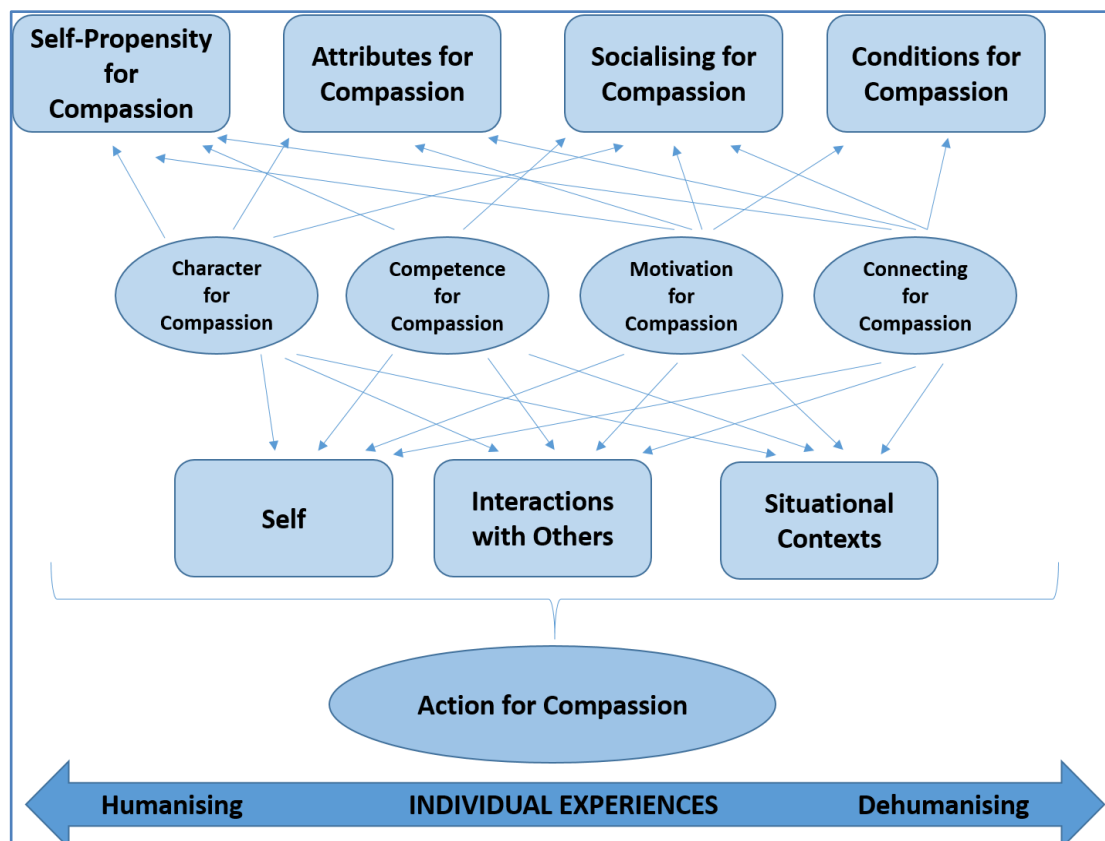
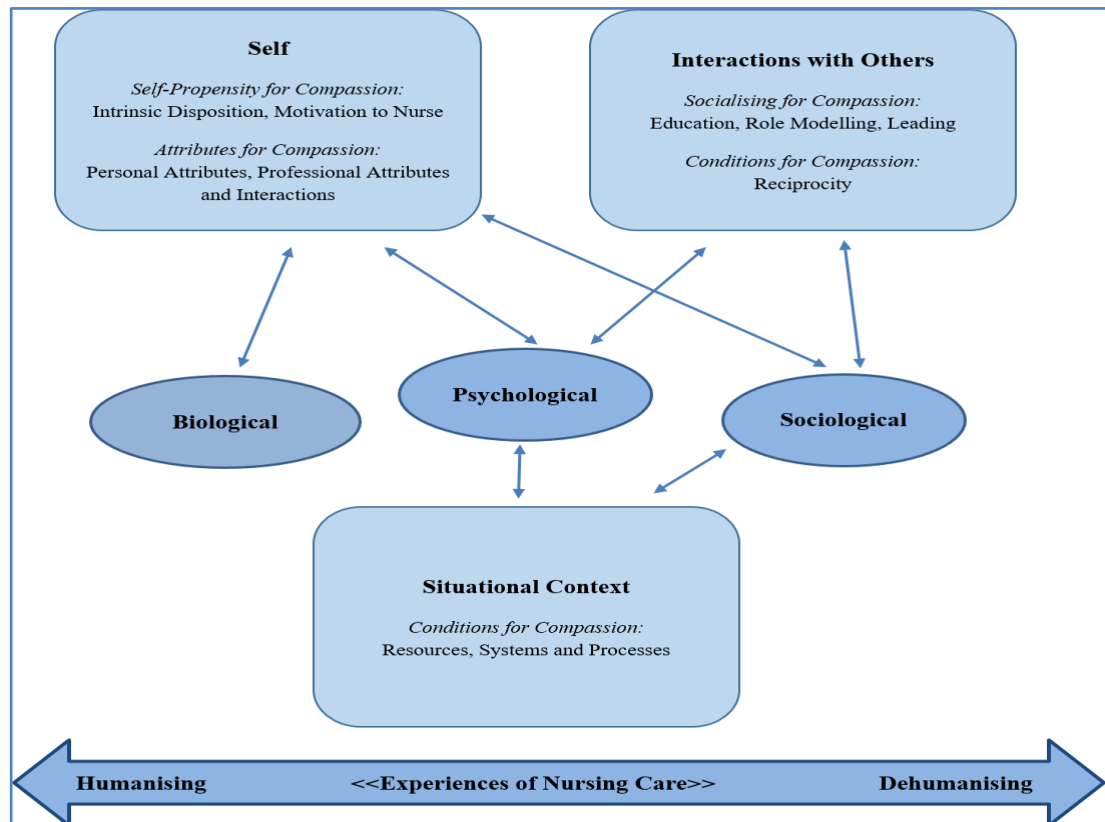
The Compassion Matrix for Humanising Nursing Care: Continuity



The Compassion Matrix for Humanising Nursing Care: Discontinuity



Appendix 19: Conceptual Maps to Identify Key Factors Influencing Construction of the Grounded Theory



October 22nd 2012:

I have reached a critical stage in the research process...now the real work starts. I have to choose one of the sample group to interview. I'm a nurse, I'm used to communicating with patients; I'm an academic, I'm used to communicating with students; but this is new, this makes me feel a little nervous... this is the reality of real life research.....I have to interview someone for my own personal research. I'm not totally clear about where to go next, who to choose or why I should choose them.

November 6th 2012:

After analysing my sampling matrix, reading the literature to re affirm why I decided to use a matrix in the first place and discussing the issue with my supervisors.....things seem clearer. I can now provide a rationale for which service user to select for the initial interview and the reasons underpinning this...I need to select a participant who can provide a generic insight into compassion and the selected individual can do this due to her extensive experience of nursing care across a wide range of environments. She is in the older age group of people who are often difficult to reach sample groups. People in her age range have reportedly experienced an array of poor quality care which lacks compassion, therefore I need to make sure that her voice is heard. I want to be inclusive, I want to listen to those who are perceived as the most vulnerable. I'm confident that she can provide a wealth of insight into compassion in nursing and that her experiences will serve as the foundation to move forward with theoretical sampling.

Appendix 21: Poster Presentation June 2014

Towards an Understanding of Compassion in Nursing: A Grounded Theory Study to Explore the Individual Perceptions of People with Experience

Collette Straughair, Senior Lecturer Adult Nursing/ Part Time PhD Student, Faculty of Health and Life Sciences

Supervisors: Dr Steve Tawse and Professor Amanda Clarke

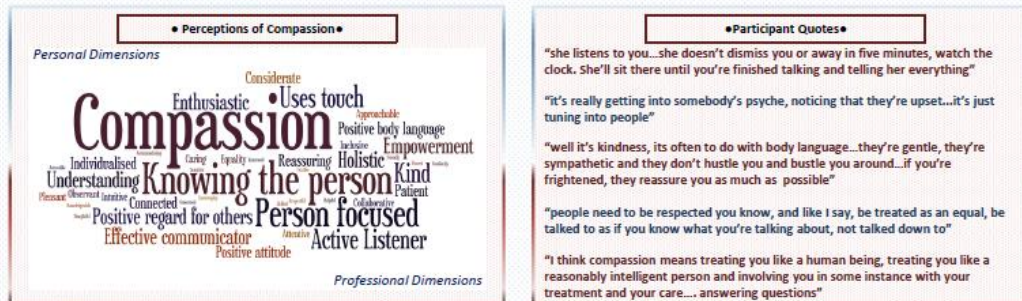
Background: The concept of compassion in nursing is traditionally regarded as a core professional value (Nightingale 1859, NMC 2008, Rafferty 2011, Bradshaw 2011). However, concerns about nursing care which lacks compassion (The Patients Association 2009, The Mid Staffordshire NHS Foundation Trust Inquiry 2010, The Parliamentary and Health Care Ombudsman 2011) have challenged this notion and led to the re endorsement of compassion as a fundamental value, integral to the profession of nursing (DH 2010, RCN 2010, DH and NMCSC 2012). Despite this, the concept of compassion has not yet been clearly defined due to the subjective and complex nature of this intangible concept, as it is perceived uniquely by each individual who experiences it (Schantz 2007, Harrison 2009, Davison and Williams 2009, Dewar et al 2011, Straughan 2012).




Methodology: Blaikie (2007) argues that knowledge is socially constructed as it is derived from the conceptualisations and interpretations of individuals in relation to their own experiences and actions, the actions of others and the context or situations in which this occurs. Therefore, a constructivist grounded theory methodology (Charmaz 2000, 2006 and Clarke 2005) was implemented to explore the concept of compassion through the individual and unique perceptions of a sample of 'people with experience'. The sample population originated from an existing group affiliated with Northumbria University in an established role to share experiences and insights with undergraduate health students.

Data Collection and Analysis: A sampling matrix was developed from data obtained via an initial questionnaire (Miles and Huberman 1994, Mactavish and Schlein 2004, Machin et al. 2012). Theoretical sampling procedures were implemented and ten semi structured individual interviews have been conducted, transcribed verbatim and analysed using initial, focused and theoretical coding techniques (Charmaz 2000, 2006). Data collection and analysis ensued simultaneously, using the constant comparative method advocated by Glaser and Strauss (1967).

Initial Findings: Participants perceive compassion as a highly complex concept, involving multiple dimensions which are influenced by a variety of factors. The dominant emerging themes relate to *Perceptions of Compassion* which includes personal and professional dimensions of compassion and *Enablers and Inhibitors of Compassion* which includes organisational structures, development of the mindful self and perceptions of the influence of biologically inherited personality traits. Key findings from the *Perceptions of Compassion* theme is presented below.

[illegible]

Appendix 22: Oral Presentation at the Association of Medical Humanities “The Art of Compassion” Conference





Towards an Understanding of Compassion in Nursing: A Grounded Theory Study to Explore the Individual Perceptions of People with Experience

Presented by: Collette Straughair
Senior Lecturer Adult Nursing / Doctoral Student
Northumbria University

Supervisors: Dr Steve Tawse and Professor Amanda Clarke

The Association of Medical Humanities
The Art of Compassion Conference
Southampton University July 7–9 2014





This is to certify that

Collette Straughair


attended

The Association for Medical Humanities' Annual Conference

THE ART OF COMPASSION

7 – 9 July 2014 at University of Southampton

The Association for Medical Humanities' annual conference provides an international interdisciplinary forum for research and teaching in the medical humanities. This conference explored the nature of compassion from historical, philosophical, cultural and global perspectives and considered how the medical humanities generate understanding and the development of compassionate practice in healthcare, through keynote speakers, delegates' papers and workshops.



Linda Turner
Medical Education Academic Unit
University of Southampton

The Art of Compassion Conference (code 90403) has been approved by the Federation of the Royal College of Physicians of the United Kingdom for 12 category 1 (external) CPD credits

Appendix 23: Oral Presentation at the North East Post Graduate Conference

HEALTHCARE

<http://ne-pg.co.uk/abstracts/healthcare>

as it is perceived and understood uniquely by each individual who experiences it.

Aims: This doctoral study aimed to explore individual perceptions of compassion and address the research question: "what does compassion mean to the individual and how do they perceive this as a result of their unique experiences of nursing care?"

Methods: A constructivist grounded theory methodology was implemented. Participants were sampled from an existing group affiliated with Northumbria University in a role to share experiences with undergraduate health students. Semi structured individual interviews giving rise to rich and detailed data were audio recorded, transcribed verbatim and analysed using initial, focused and theoretical coding techniques.

Results:

Two overarching themes emerged following data analysis:

- Individual perceptions of compassion- characterising what compassion means to participants, incorporating elements related to personal and professional dimensions of compassion.
- Enablers and inhibitors of compassion- highlighting factors impacting compassion, involving issues related to development of the mindful self, the influence of structure and the biology of selection.

Conclusions: Data analysis suggests that compassion involves a highly complex network of concepts which are interwoven and interdependent, all of which interact to influence individual perceptions of compassion in nursing. This results in significant emerging implications for practice in terms of issues such as recruitment, education, leadership and organisational culture.

COLLETTE STRAUGHAI

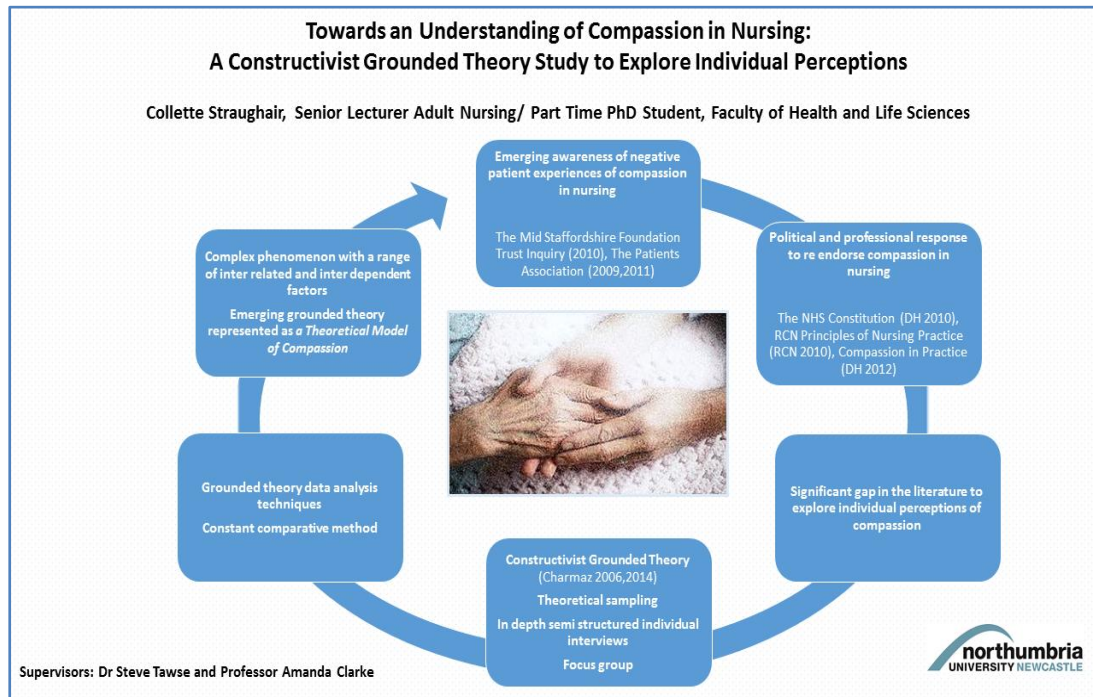
NORTHUMBRIA UNIVERSITY

10:35 -10:50

Exploring individual perceptions of compassion in nursing

Introduction: Concerns regarding a plethora of negative patient experiences have led to the re-endorsement of compassion as a core professional nursing value. However, the notion of compassion requires further investigation due to the subjective and complex nature of this intangible concept,

Appendix 24: 3 Minute Thesis at Northumbria University Post Graduate Researcher Conference



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